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ABSTRACT

This report includes information conerning demographic trends affecting children over the past few years, the status of children as determined by critical normative data pertaining to their health, education, welfare and the identification and targeting of programs and services to meet the needs of children. Section I covers demographic trends in the seventies; Section II is concerned with general classes of developmental problems and relevant programs; and Section III is a discussion of analytical methods for deriving indices of developmental risk and ways resources might possibly be targeted more efficiently and equitably. Included are many graphs, charts and tables providing such information as fertility and mortality rates, social and economic data on families, and data on day care facilities, preschool and school enrollment, community services, health, nutrition, child abuse, juvenile delinquency and welfare. Also included is a list of federal programs. (MS)

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The Status of Children 1975

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The Status of Children 1975

by

Kurt J. Snapper, Ph.D.
Harriet H. Barriga
Faye H. Baumgarner
Charles S. Wagner

Social Research Group
The George Washington University
1975

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FOREWORD

This is a report for those concerned about children. It is filled with important information concerning demographic trends affecting children over the past few years, the status of children as determined by critical normative data pertaining to their health, education, and welfare, and the identification and targeting of programs and services to meet the needs of children.

A major issue highlighted in this report is the need to develop more sensitive measures of developmental risk, which may be used to identify target groups needing services and programs. A sharp break is made with techniques that rely upon demographic data as surrogates for normative data on the health, education, and welfare of children. The analytical procedure proposed in this document uses, instead, normative measures to examine critical relationships, and incorporates demographic data as correlates rather than as surrogates. Thus, to illustrate, health and education data are seen as more critical indicators of developmental risk than is a surrogate, poverty.

The information included in this report draws upon statistical data concerning numbers and conditions, taken from the Information Retrieval and Analysis System (IRAS), and information about currently funded research. Research information is available from the Interagency Research Information System (IRIS), which covers research projects on children and youth funded by agencies of the Federal government.

This is a first effort to establish a biennial report on the status of children. Your reaction to it, suggestions for change or expansion, and comments about its usefulness are solicited.

Edith H. Grotberg

Edith H. Grotberg, Ph. D.
Chairperson,
The Interagency Panel on Early
Childhood Research and Development
Director, Research and Evaluation Division,
Office of Child Development, D/HEW

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TABLE OF CONTENTS

Page
FOREWORD v
ACKNOWLEDGMENTS. vi
LIST OF FIGURES. ix
INTRODUCTION 1
SECTION 1: Demographic Trends in the 1970's 3
SECTION 2: The Status of Children 17
SECTION 3: Targeting of Programmatic Resources. 41
Indices of Developmental Risk. 41
Problem Identification and Service Provision . . . 54
Conclusions. 58
APPENDICES 63
Appendix 1 Tables 63
Appendix 2 Federal Programs 97
BIBLIOGRAPHY 101

LIST OF FIGURES

	Figure	Page
1.1	Population in Metropolitan Areas: 1974	3
1.2	Fertility Rates in the United States: 1965 to 1973	4
1.3	Leading Causes of Death Among Infants and Children: 1970	5
1.4	Maternal Mortality: 1963 to 1973	6
1.5	Infant Mortality: 1965 to 1974	6
1.6	Percent Children Under 18 Years Old Living With Both Parents: 1967 to 1973	7
1.7	Number of Divorces and Annulments and Estimated Number of Children Involved: 1963 to 1972	8
1.8	Labor Force Participation of Married Women With Children, Husband Present: 1965 to 1974	9
1.9	Labor Force Participation of Married Women With Children by Race: 1973	9
1.10	Labor Force Participation of Married Women With Children by Husband's Income: 1973	10
1.11	Median Family Income: 1973	11
1.12	Percent of Children Under 18 Years Old in Poverty Families: 1974	12
1.13	Percent of Children Under 18 Years Old in Poverty Families: 1967 to 1974	12
1.14	Distribution of AFDC Funding: 1973	13
1.15	Estimated Number of Children Adopted: 1962 to 1971	14
1.16	Percent of Highschool Dropouts 14 to 24 Years Old: 1967 and 1973	14
2.1	AFDC Recipients and Payments: December, 1965 to December, 1974	17
2.2	Licensed or Approved Day Care Facilities: 1972	19
2.3	Preprimary School Enrollment: October, 1973	20
2.4	Preprimary School Aged Children Enrolled in Nursery School and Kindergarten: October, 1964 to October, 1973	21
2.5	Modal Grade Enrollment: October, 1972	22
2.6	Percent of Handicapped Pupils Receiving Special Instruction or Assistance in School: Spring, 1970	22
2.7	Percent Population Aged 1-5 Years Below Nutritional Standard: 1971 to 1972	25

LIST OF FIGURES
(Continued)

Figure Page

2.8 Number of Children Participating in the National School Lunch Program: 1968 to 1974 26

2.9 Patient Care Episodes Under 18 Years of Age by Type of Psychiatric Facility: 1971 29

2.10 Admissions to Outpatient Psychiatric Services: 1970 to 1971 29

2.11 Percent Arrests of Persons Under 15 Years of Age: 1973 31

2.12 Criminal Victimization: 1973 32

2.13 Motivation for Abuse of All Drugs Nationwide: July, 1973 to February, 1974 34

2.14 Reported Cases of Venereal Disease: 1963 to 1974 37

2.15 Congenital Syphilis: 1957, 1965, 1974 37

2.16 Reported Cases of Selected Communicable Diseases in the United States: 1964 to 1973 38

2.17 Major Immunizations for Children 1-4 Years Old: 1966 to 1974 38

3.1 Health Risk as a Function of Health Score 42

3.2 Educational Risk as a Function of Education Score 43

3.3 State Ranking by Health Score 44

3.4 State Ranking by Education Score 44

3.5 Health Score by Education Score 47

3.6 Education Score by Poverty 50

3.7 Education Score by Percent Black 50

3.8 Health Score by Poverty 51

3.9 Health Score by Percent Black 51

3.10 Correlations Within Subpopulations 53

Introduction

In the first half of the 1970's, there have been rapid changes, both in the conditions surrounding children and in the programs designed to benefit them. The Status of Children 1975 was prepared as an attempt to document these changes, and to provide the most recent data pertaining to children, families, and programs designed to benefit them. We made no attempt to provide a comprehensive catalog of available statistics but chose, instead, to highlight conditions and trends that, to us, seemed most salient.

In preparing The Status of Children 1975 we drew heavily upon the Information Retrieval and Analysis System, maintained by the Social Research Group. This system routinely compiles data from numerous Federal agencies, and other sources of relevant information. Included among these agencies are the members of the Interagency Panels on Early Childhood and Adolescence. Other agencies throughout the government also have kindly provided us with those data we requested, often in pre-publication form, and patiently supplied answers to our questions. The fact that this report was possible testifies to the concern for children, youth, and families, at all levels and in all departments. We gratefully acknowledge such contributions, but hasten to add that the authors must bear full responsibility for analyses based upon those data we used, as well as for the accuracy of our interpretation.

The Status of Children 1975 is divided into three sections. The first discusses demographic trends since the last decennial Census. We attempted to highlight those trends most relevant to programs and policy decisions, selecting data that are frequently used to define target populations, or to establish eligibility requirements. Insofar as practicable, we tabulated data by economic status or ethnic identity.

The second section is oriented less toward demography, and considers general classes of developmental problems, and relevant programs. The large number of programs relevant to children and families precluded any comprehensive discussion. Many of these are listed in Appendix 2, for the interested reader. Programs are designated by numerical codes assigned by the Office of Management and

Budget, in the 1974 Catalog of Federal Domestic Assistance. Information about programs in Appendix 2 and those mentioned in the text of Section 2 was also obtained from DHEW Programs Affecting Children: A Summary Report for 1975, prepared by the DHEW Committee on Children. Readers interested in additional information about programs should refer to those documents.

The third section discusses analytical methods for deriving indices of developmental risk. Within this context, we present an overview which examines how selected programs are targeted, and discuss ways in which resources might be targeted perhaps more efficiently and more equitably.

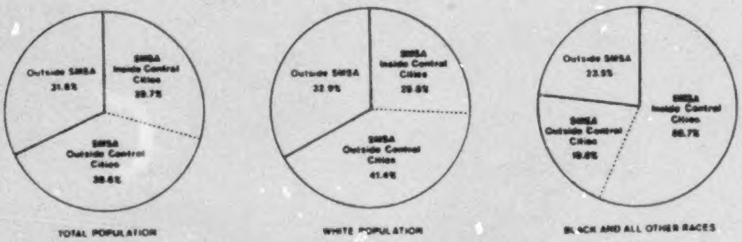
All figures were prepared by Project personnel. Data from which figures in sections 1 and 2 were prepared are shown in tabular form in Appendix 1. Tables in Appendix 1 are keyed numerically to the figures.

1

Demographic Trends in the 1970's

The early 1970's have witnessed important changes in the demographic profile of American families, and in the life style of many of their children. During the relatively short time frame covered by this report, some new trends have emerged, some "historic" trends have proved not so historic, and others have accelerated.

American society has been predominantly urban for a century, and in 1974, as Figure 1.1 shows, 68.3% of the population lived in metropolitan areas compared to 31.6% who resided in non-metropolitan areas. Traditionally, metropolitan areas have attracted persons from rural areas, and have accommodated immigrants from other countries. Yet the early 70's showed a marked slowing down of this rural to urban shift. During the 1960's, the metropolitan areas grew at a rate of 16.6%, while between 1970 and 1974 this growth was only 3.8%. In contrast, the non-metropolitan areas grew almost as much (5%) during 1970-74 as they did during the entire decade of the 60's (6.8%). Simultaneously, there has been a slowing of the long-standing migratory flow from the southern to northern portions of the country.



SMSA: Standard Metropolitan Statistical Area, as defined by Census

Figure 1.1 Population in Metropolitan Areas: 1974

The majority of American families, 68%, were metropolitan residents in 1974. Overall, 82% of Spanish-origin families lived in metropolitan areas. Over 90% of the Puerto Rican families lived in metropolitan areas, compared to 75% of the Mexican-American families. Overall, 66.4% of White families lived in metropolitan areas, compared to 77.1% of Black families.

Trends in migration and metropolitan growth may be affected by the fact that families are having fewer children. In the United States the fertility rate reached its lowest point in history: in 1973 there were 69.2 births per 1,000 women between the ages of 15 and 44. This 1973 rate was 6% below the 1972 rate (73.4 births per 1,000 women) and 44% lower than the 1957 rate (122.7 births per 1,000 women). Births began to fall relatively rapidly in 1970, compared to rates in the latter half of the 1960's. Although fertility rates for non-Whites remain higher than for Whites, rates for both groups have dropped rapidly in the 1970's (see Figure 1.2). Overall, birth rates may have begun leveling off in 1974--a possible prelude to both increased birth and fertility rates.

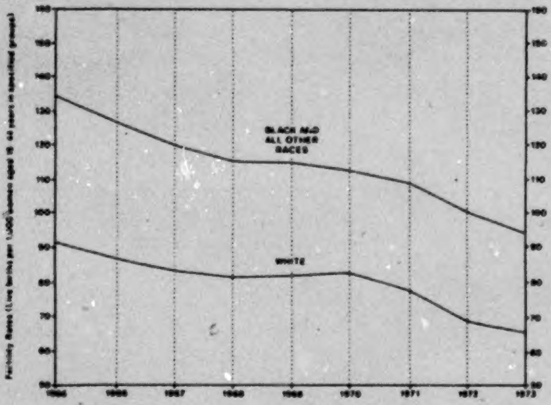


Figure 1.2 Fertility Rates in the United States 1965 to 1973

The fertility rate, at least in 1974, dropped below the level required for population replacement, if net immigration is not counted. The average household size--2.97 persons--was also a record low. Women with no high school education average between one and two more children than those who graduate from college.

Handicapping conditions, disease, and accidents are threats to a child's health and well-being. About 7% of live births, or 200,000 children annually, develop handicaps resulting from congenital anomalies. The incidence of communicable disease has shown a long-term decrease as a result of immunization. But the accidental death rate for children has not shown a consistent decline. In 1973, 14,800 children under the age of 15 died in accidents. The accidental death rate for children under 5 was 35.3 deaths per 100,000 population, a drop of 18% since 1963. But for children 5 to 14 years of age, the 1973 rate was 21.3 accidental deaths per 100,000 population, a 16% increase in the same ten-year span. As Figure 1.3 shows, motor vehicle accidents are the leading cause of accidental death among children over 1 year of age.

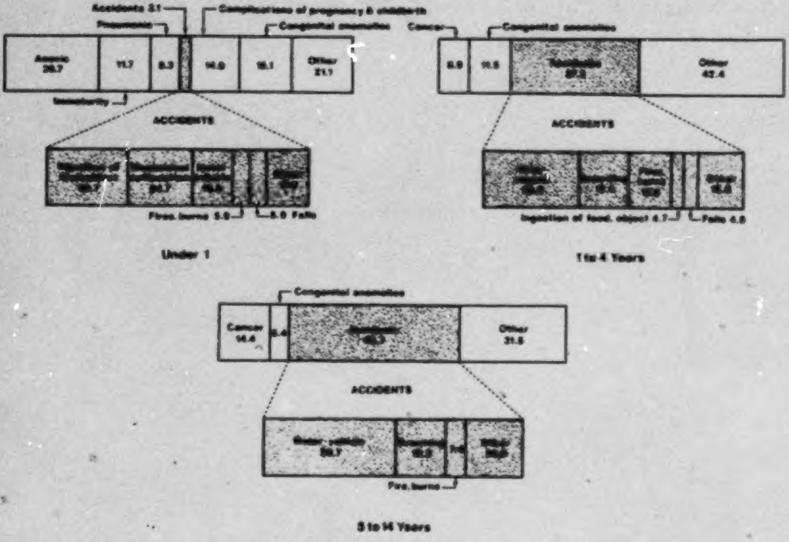


Figure 1.3 Leading Causes of Death Among Infants and Children: 1970

Although maternal mortality rates for non-Whites remain higher than for Whites, the decline in mortality rates has been more rapid among non-White mothers, as Figure 1.4 indicates. The same was true of infant mortality rates from the mid-1960's through the early 1970's. While the overall infant mortality rate has declined, the rate for non-Whites remains higher than for Whites, as Figure 1.5 indicates, though the trend has been for a lessening of differences.

Changes in the size of families have been accompanied by changes in the structure of families and the roles of parents. For

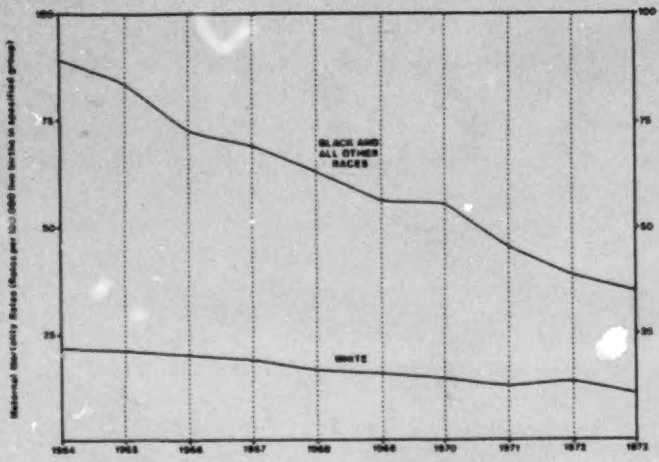


Figure 1.4 Maternal Mortality: 1964 to 1973

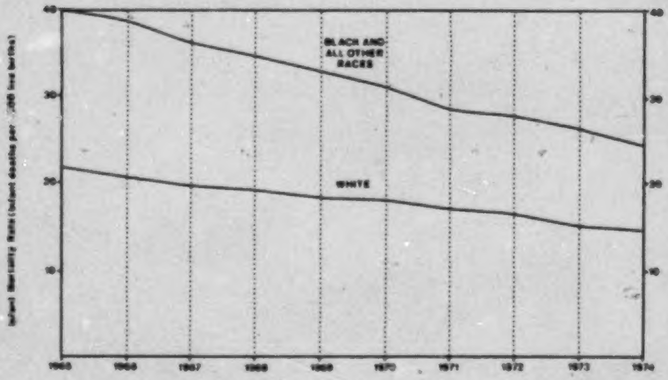


Figure 1.5 Infant Mortality: 1965 to 1974

example, there was an 18% increase in the number of female family heads between 1970 and 1973, compared to a 24% increase in the entire preceding decade. In March 1974, the percentages of Black families and White families headed by females were 34.0 and 10.0 percent; overall, 12.4% of American families were headed by females. The percentage of single-parent families headed by males was only 2.6%. What about the living arrangements of children? In 1973, about 6% fewer White children and 15% fewer Black children lived in husband-wife families, compared to 1970 (see Figure 1.6).

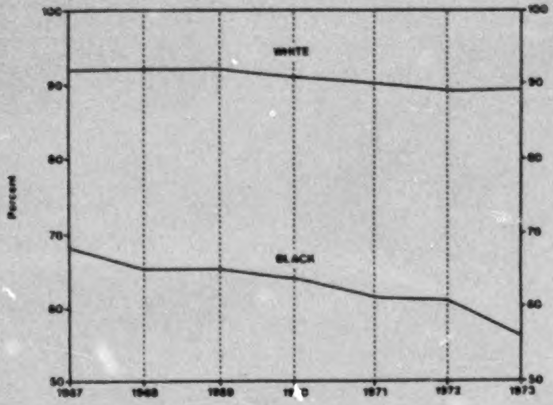


Figure 1.6 Percent Children Under 18 Years Old Living With Both Parents: 1967 to 1973

The percentage of female-headed and husband-wife families with children under six is approximately the same. In 1974 (March), about 26% of husband-wife families and about 24% of female-headed families had children under six, compared to about 5% of male-headed families. However, female-headed families are more likely than husband-wife families to have children under 18. Overall, 60% of the female-headed families have children under 18, whereas 54% of husband-wife families and 27.1% of male-headed families have children under 18. Black families, regardless of family type, were more likely to have children than White families.

The year 1974 saw an increase of 6% in the number of divorces over the number recorded in 1973, and a large number of children were involved, although exact figures for 1974 are not yet available. In 1972, more than one million children and youth under 18 were involved in divorces, an increase of almost 8% from 1971 (see Figure 1.7). This figure reflects a sharp rise in the number of divorces involving children. However, the average number of children involved per decree fell to 1.20--the lowest since 1960--which appears to reflect recent decreases in fertility rates.

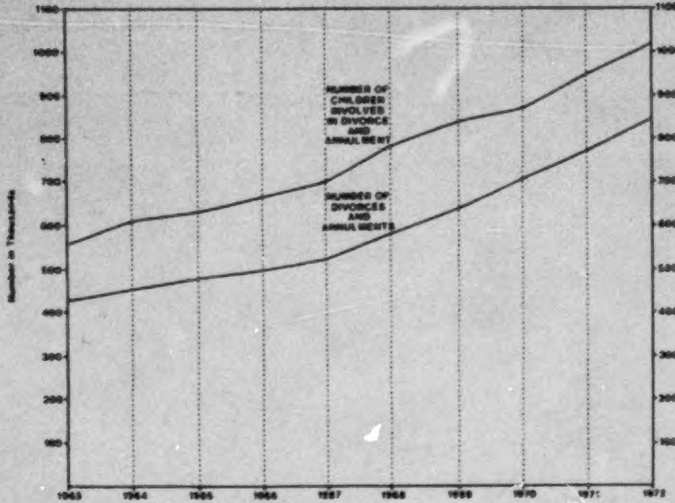


Figure 1.7 Number of Divorces and Annulments and Estimated Number of Children Involved: 1963 to 1972

The current trend is for women, especially married women, to join the labor force. This trend is roughly two decades old. At the same time, the labor force participation rate for married men has decreased. Between 1953 and 1973 the participation rate for married men fell from 92% to 85%, while the rate for married women rose from 26% to 42%. The decrease for men is largely attributable to males 55 and over who are limited in their activities or unable to work because of health problems; therefore relatively few young children are directly affected.

The increasing number of working women, on the other hand, greatly affects the young. In March 1974, 43% of all married women were in the labor force. The ages of their children appeared to affect their decision to work. About 34.4% of women with children under 6 were in the labor force, compared to 51% for those with children between 6 and 17 (see Figure 1.8). Labor force participation for women with preschool children (under 6) rose between 1970 and 1974, with the sharpest rise (26% to 31%) for mothers with children under 3. Among mothers whose youngest child was between 3 and 5, the increase during the same period (March 1970 to March 1974) was from 37% to 39%. Labor force participation rates of married women with children by race and by income of husband are shown in Figures 1.9 and 1.10.

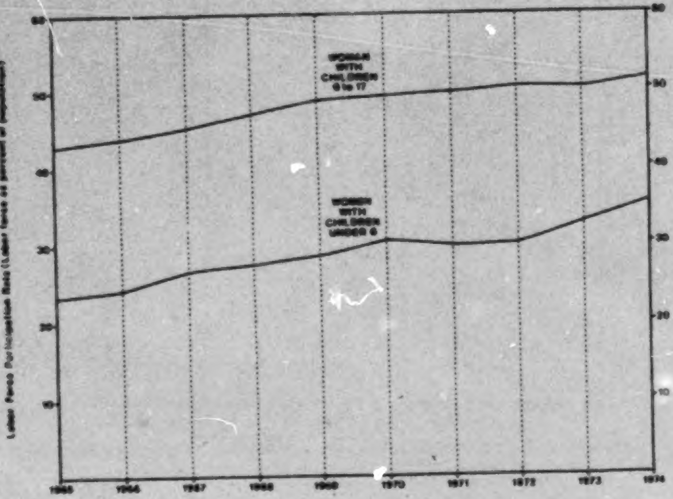


Figure 1.8 Labor Force Participation of Married Women with Children, Husband Present: 1965 to 1974

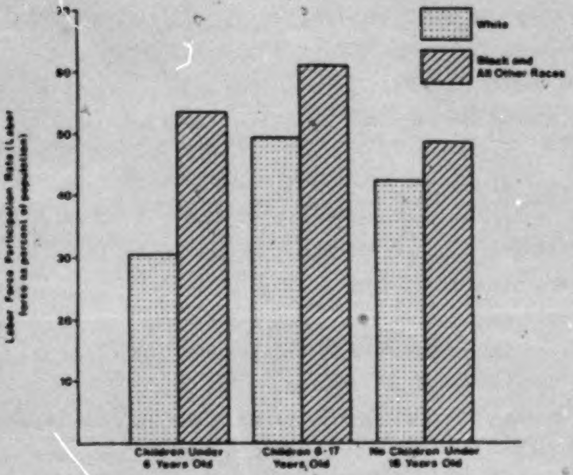


Figure 1.9 Labor Force Participation of Married Women With Children by Race: 1973

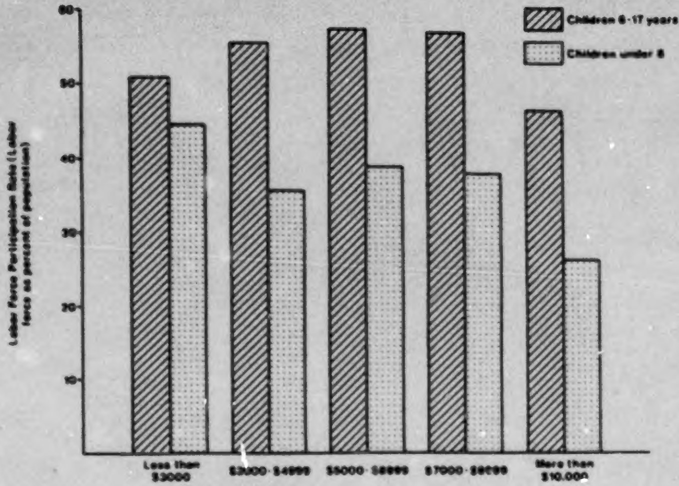


Figure 1.10 Labor Force Participation of Married Women With Children by Husband's Income: 1973

More than half of all female heads of families were in the labor force--54.1% in March 1974. This rate has remained fairly constant over the past several years.

Data for 1969-1972 suggest that the median income for female-headed families decreased relative to husband-wife families. As Figure 1.11 indicates, in 1973 families headed by Black females had the lowest median income, $4,226, compared to $6,560 for families headed by White females.

The percentage of families below the poverty level (set at $5,038 for a nonfarm family of four in 1974) increased appreciably between 1973 and 1974. In 1973, there were 9.5 million related children under 18 in families with incomes below the poverty level. Between 1973 and 1974 this figure increased by 8% to 10.2 million, increasing the overall percentage of children who are in poverty families from 14.2% to 15.5%.

The increase in number of poverty-level families--to 5.1 million in 1974--followed a period (1971-1973) during which the number of families in this economic bracket continued to decline. The overall increase in number of families below the poverty line in 1974 was 5.8% over the 1973 figure, but for families headed by a female the increase was greater—7.2%. For male-headed families the increase was only 4.6%.

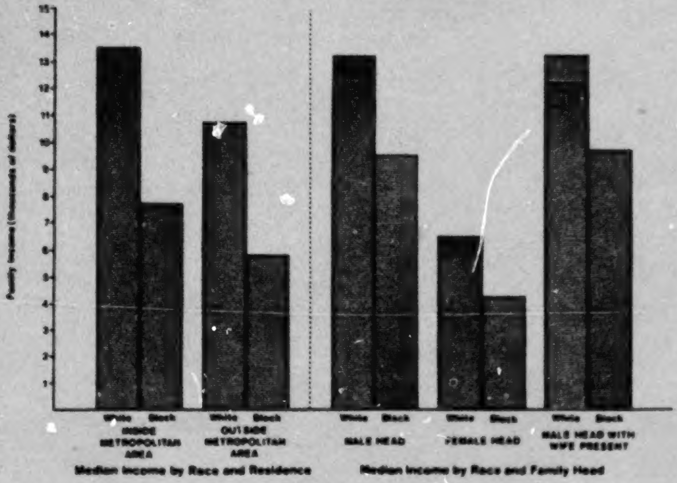


Figure 1.11 Median Family Income: 1973

The number of persons in White families below poverty increased from 11.4 million in 1973 to 12.5 million in 1974, a 9.6% jump; the number of persons in Black families below the poverty figure declined by 1%, to about 6.5 million in 1974. The number of White female-headed families below poverty rose by 9% to about 1.3 million; the corresponding increase for Black female-headed families was 5.1%, to about 1 million.

In 1973, families below the poverty level were more likely to have children under 18 than families with higher incomes (73% versus 55%). Female-headed families below the poverty level also were more likely to have children than male-headed families. In 1974, the poverty rate for all female-headed families with children was 51.5%. Among Black female-headed families with children, 65.7% were in the poverty bracket in 1974, as compared to 42.6% for White female-headed families (see Figure 1.12). Figure 1.13 shows the percentage of children under 18 in poverty-level families by race.

These statistical shifts have an impact on Aid to Families with Dependent Children, which provides assistance to many families.

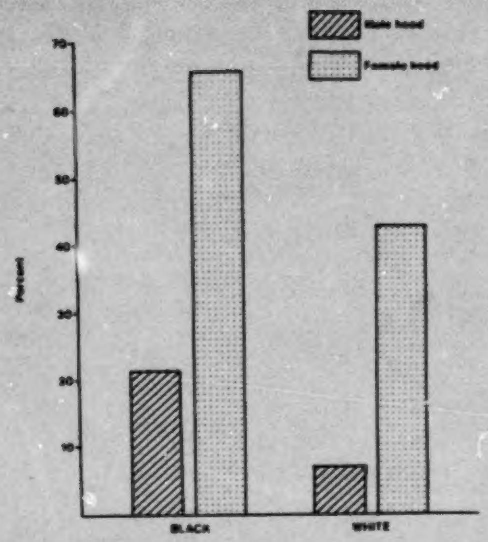


Figure 1.12 Percent of Children Under 18 Years Old in Poverty Families: 1974

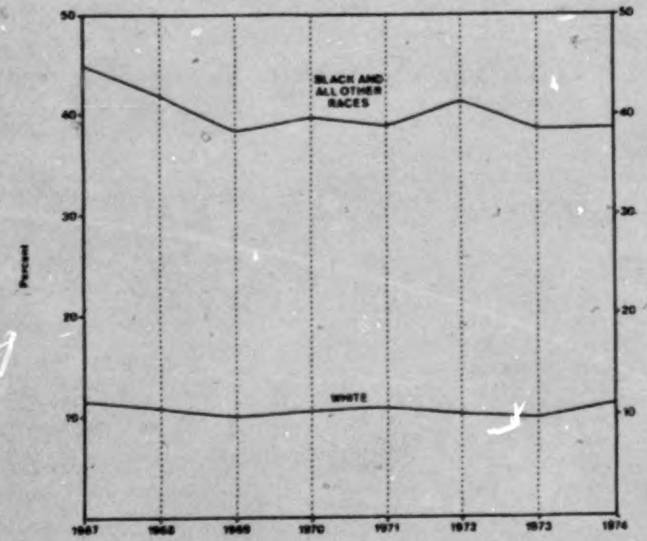


Figure 1.13 Percent of Children Under 18 Years Old in Poverty Families: 1967 to 1974

AFDC assistance was provided to about 3.0 million families in 1973, an increase from about 2.5 million in 1971. In 1973, 93.4% of AFDC families included a mother, whereas only 12.7% included a father. A majority of AFDC families include a child under 6 years of age, and more than half of all children in AFDC families are under 8 (see Figure 1.14).

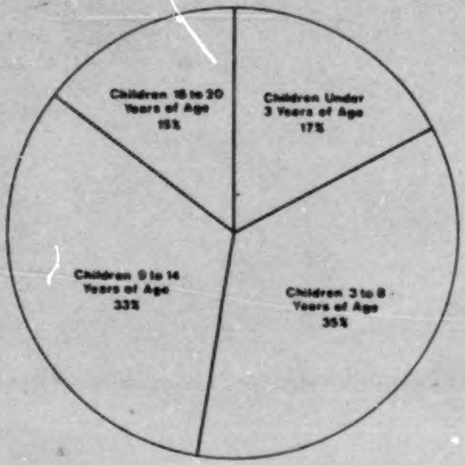


Figure 1.14 Distribution of AFDC Funding: 1973

In recent years, the number of adoptions has been declining. The most recent complete data on adoptions indicate that, in 1971, 169,000 children were adopted, a somewhat smaller number than the 175,000 who were adopted in 1970, and an unprecedented break in the trend of steadily increasing numbers of adoptions between 1957 and 1970 (see Figure 1.15). Over this same time period, 1957 through 1970, the rate (number of adoptions per 10,000 population under 21) had also increased in each successive year. For example, the rate was 15.0 in 1960 and by 1970 it had risen to 21.7. In 1971, the rate dropped to 21.0. In part, this decrease may be linked to the increased availability of legal abortions (approximately 587,000 were performed in 1972), falling birth rates, and the increase in the number of single women who are choosing to keep their babies.

As birthrates decline, school enrollments decline. From 1971 to 1972, elementary and secondary school enrollments decreased

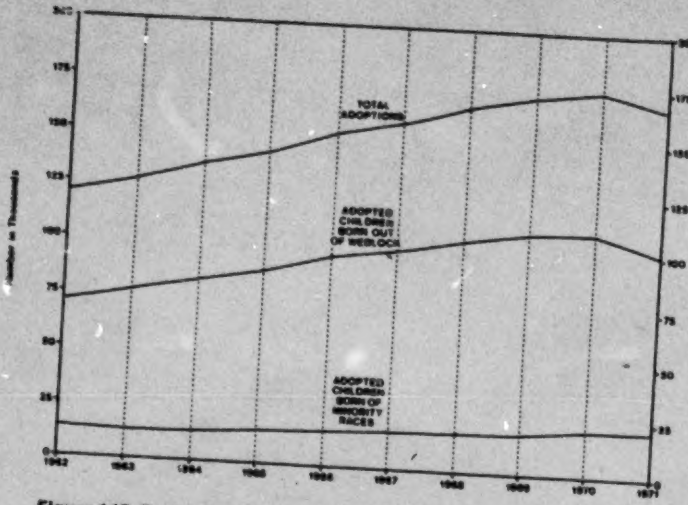


Figure 1.15 Estimated Number of Children Adopted: 1962 to 1971

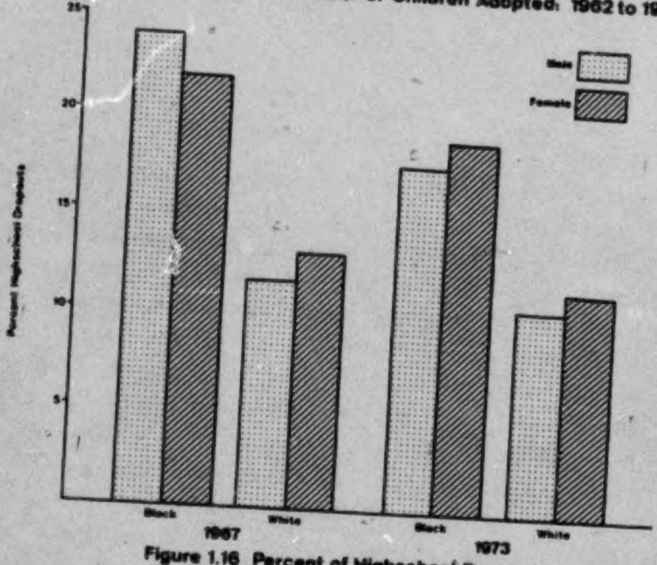


Figure 1.16 Percent of Highschool Dropouts
14 to 24 Years Old: 1967 and 1973

(from 46.1 million to 45.8 million) for the first time since 1943-44. Although this decrease was only .7%, projections indicate an additional 1.3 decrease to 44.7 million in 1977-78, followed by an increase to 45.5 million in 1981. Part of the projected rise in enrollments after 1978 is attributed to an expected increase in the percentages of 18 year-old graduates from high school, from 75.9% in 1971 to 85.7% in 1981. This tendency for students to stay in school longer is evident from the decrease in the percentage of high school dropouts, especially among Blacks, between 1967 and 1973 (see Figure 1.16).

2

The Status of Children

Income Assistance

In 1974 there were approximately 10.2 million children under 18 in low-income families; 3.29 million of them were under 6 years of age. In the early 1970's, there was a slight decline in the number of persons below the poverty level. However, in 1973-1974 the number of persons below the poverty level increased by about 1.3 million--despite the fact that the poverty level had been raised to reflect inflation. Other data pertaining to low-income groups were discussed in Section 1. A variety of income assistance and service programs is targeted upon low-income persons, families or areas.

Public Assistance-Maintenance Assistance (State Aid)(13.761) grants money payments through States to low-income families with dependent children; these payments are used to pay for basic necessities. One component, Aid to Families with Dependent Children (AFDC), involved about 3.0 million families in 1973, an increase of 18% from 1971. However, partly due to trends toward smaller families (the average AFDC family decreased from 3.8 to 3.6 members) the increase in the number of recipients from December 1971 to December 1973 was not as dramatic (see Figure 2.1). Families of Native Americans

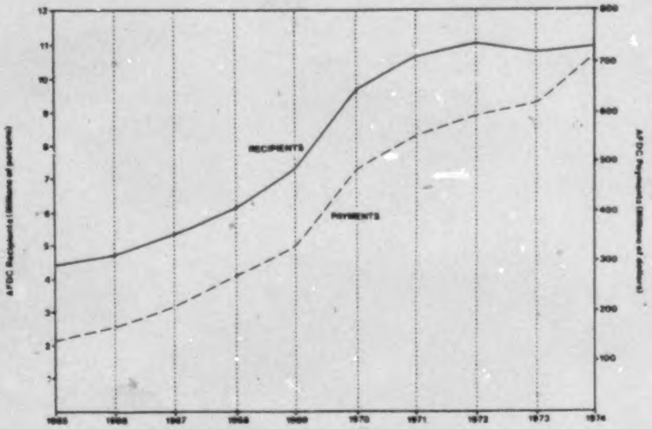


Figure 2.1 AFDC Recipients and Payments: December 1965 to December 1974

may qualify for aid through the Indian Social Services-General Assistance program (15.113) if they live on or near Indian reservations where aid is not available from State or local public agencies.

The Social Security system and the Veterans Administration provide assistance to qualified families, regardless of income level. The programs which affect children, directly or indirectly, include the Social Security-Survivors Insurance Program (13.805), Disability Insurance (13.802), Retirement Insurance (13.803), Special Benefits for Disabled Coal Miners (13.806), Supplemental Security Income (13.807), Pensions to Veterans Widows and Children (64.105), Veterans Dependency and Indemnity Compensation for Service-Connected Deaths (64.110), and Compensation for Service-Connected Deaths for Veterans, Dependents Program (64.102). Other programs that provide assistance, support, or social services include Child Development-Head Start (13.600), Child Development-Child Welfare Research and Demonstration Grants (13.608), Public Assistance-Social Services (13.754), Public Assistance Research (13.766), Work Incentives Program (17.226), Educationally Deprived Children in State Administered Institutions Serving Neglected or Delinquent Children (13.431), and Community Service Training Grants (13.768).

Preschool Programs and Education

A broad range of educational programs are targeted on specific groups: preschool children, handicapped children, children in institutions, children in migrant families, members of ethnic minorities, children whose maternal language is not English, children in low-income families, children from rural areas, and those who are potential school drop-outs. The programs described below are designed to meet the special needs of their various target populations.

As noted earlier, increasing numbers of mothers are joining the labor force; the number of children under 6 who had working mothers was approximately 5.6 million in 1972. Data for 1971 indicated a total capacity of about 912,000 in approved or licensed day-care centers and family day-care homes, and incomplete data for 1972 showed a capacity of about 821,000 (see Figure 2.2). Thus, there are slots for less than 20% of the children under 6 in licensed or approved day care facilities. The Work Incentives Program-Child

Care-Employment Related Supportive Services (13.748) provides child-care services to AFDC recipients participating in WIN employment and training activities. As of the last day of the quarter ending December 31, 1973, nearly 56,000 children under six were provided child care while their mothers or caretakers participated in the Work Incentives Program (17.226). Of these children, 53% were provided care either in their own home or at a relative's home, 40% were provided care in day-care facilities, and 7% received care through other arrangements. A related program, Public Assistance-Social Service (13.754) provides child-care services to recipients of public assistance.

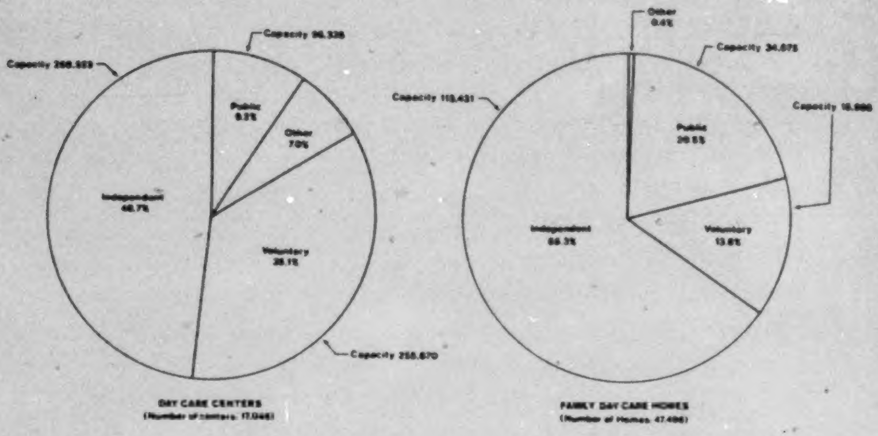


Figure 2.2 Licensed or Approved Day Care Facilities: 1972

The percentage of eligible children enrolled in nursery school or kindergarten increased steadily between 1964 (25.5%) and 1972 (41.6%), although there was a slight decrease to 40.9% in 1973. Because the majority of nursery schools are operated under private auspices, most nursery school students attend private schools. However, at the kindergarten level many programs operate under public auspices resulting in a majority of kindergartners attending public schools (see Figure 2.3). Over half of the children enrolled in preprimary programs came from families with incomes over $10,000.

The majority of preschool programs are for kindergarten children, and are administered at the local level. A large number of

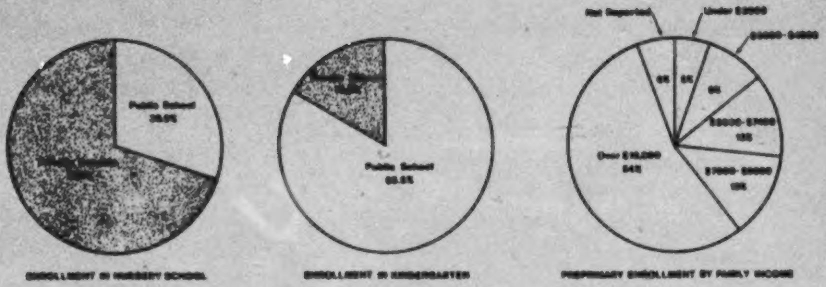


Figure 2.3 Preprimary School Enrollment, October, 1973

children, primarily from low-income families, are served by the Federally sponsored Head Start program (13.600). Head Start reached about 350,000 children in FY '75, about 15-20% of the eligible population. Head Start is not exclusively targeted upon low-income families. Up to 10% of Head Start children may be from non-poverty families and current requirements stipulate that at least 10% of the children in Head Start must be handicapped children. A companion program, Follow Through (13.433), is designed to augment and sustain gains made by children who have participated in Head Start and other preschool programs. However, it served only a portion of the children leaving Head Start and other programs--78,000 children in FY '75. Related programs include: Appalachian Child Development (23.013); Educationally Deprived Children--Special Grants for Urban and Rural Schools (13.511); Handicapped Early Childhood Assistance (13.444); and Handicapped Preschool and School Programs (13.449).

The percentage of 3 to 5 year olds enrolled in preprimary programs has increased steadily over the last decade (see Figure 2.4). It is estimated that 84% of five-year olds are enrolled in school, as compared to 99% of children between the ages of 6 and 13. In addition to increased preschool enrollments, dropout rates are declining. Two programs are designed to keep students in school. One, the Dropout Prevention Program (13.410), is designed to keep elementary and secondary students in school through the use of innovative methods, materials, systems, or programs. In FY '74, nine demonstration projects in the Dropout Prevention Program were continued; dropout rates decreased, and projects with reading and math components have reported average gains of 1.5 to 2.0 years in student achievement. The other program, Federal Employment for Disadvantaged Youth-Part Time (Stay-in-School Campaign)(27.003), is designed to provide part-time employment opportunities for disadvantaged persons, 16 through 21, so that they may continue their education without interruptions caused by financial pressures. In FY '76, participation is expected to be 21,000 youths per month, an increase of 4,000 per month over 1975.

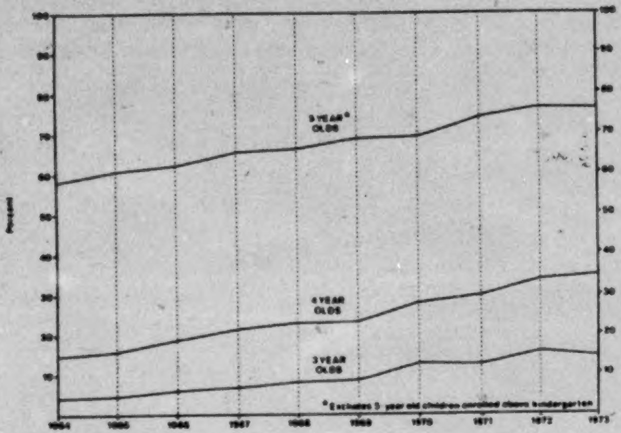


Figure 2.4 Preprimary School Aged Children Enrolled in Nursery School and Kindergarten: October, 1964 to October, 1973

As Figure 2.5 shows, most elementary school children are enrolled in their modal grade, although a larger percentage of Black than White children is enrolled below modal grade level. A larger percentage of Black than White children also is enrolled above modal grade level.

Special instruction is available in many public school systems to handicapped pupils. The proportion of handicapped pupils receiving special instruction varies with the type of handicap (see Figure 2.6). Handicapped pupils except for the mentally retarded and hard of hearing are most likely to receive specialized instruction at the elementary level.

The following programs provided educational services for handicapped children at the preschool, elementary and secondary levels in FY '75: Handicapped Preschool and School Programs (13.449),

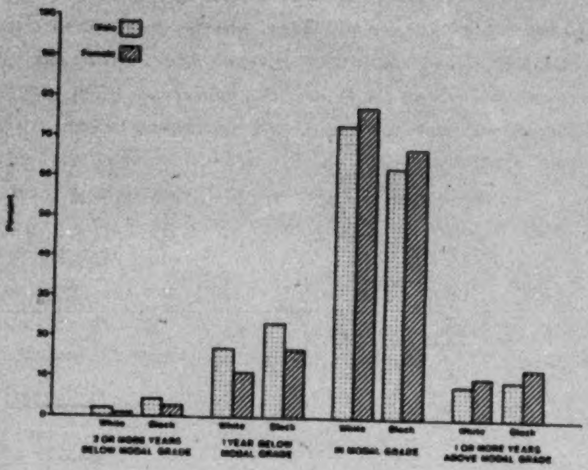


Figure 2.5 Modal Grade Enrollment: October, 1972

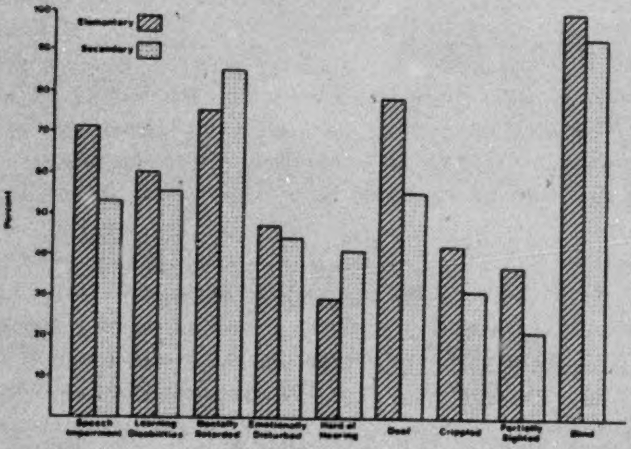


Figure 2.6 Percent of Handicapped Pupils Receiving Special Instruction or Assistance in School: Spring, 1970

which assisted in developing programs for handicapped children from preschool through secondary school levels; Handicapped Innovative Programs-Deaf-Blind Centers (13.445), which offered diagnostic, educational, and consultative services to approximately 3,800 deaf-blind children and their families; the Handicapped Regional Resource Centers Program (13.450), which provided comprehensive services for 40,000 handicapped children, and Educationally Deprived Children-Handicapped (13.427), which served about 184,000 handicapped children in State-operated or supported schools in FY '75. Other programs providing services to handicapped children include: Handicapped Early Childhood Assistance (13.444), Special Programs for Children with Specific Learning Disabilities (13.520), Handicapped Physical Education and Recreation Research (13.447), Handicapped Research and Demonstration (13.443), and Handicapped Media Services and Captioned Films (13.446).

Although some programs are not targeted specifically upon the handicapped, they may indirectly benefit the handicapped. Supplementary Educational Centers and Services-Special Programs and Projects (13.516) is one program that sets aside a given proportion of its funds (at least 15%) to aid the handicapped.

Through a number of other programs, educational services are provided for neglected and delinquent children in institutions, children of migratory workers, American Indian children, low-income children, and the bilingual population. Through the program Educationally Deprived Children in State Administered Institutions Serving Neglected or Delinquent Children (13.431), approximately 50,000 children were served in FY '75. In FY '75, 430,000 children of migratory workers were served through the Educationally Deprived Children-Migrants program (13.429). Programs which serve American Indian children include: Indian Education-Grants to Local Educational Agencies (13.534); Indian Education Special Programs and Projects (13.535); Indian Education Grants to Non-Federal Educational Agencies (13.551), Indian Education-Federal Schools (15.110); and Indian Education-Assistance to Non-Federal Schools (15.130). Educationally Deprived Children-Special Grants for Urban and Rural Schools (13.511) and Educationally Deprived Children-Local Educational Agencies (13.428) are two programs which are targeted on low-income children. Through the Bilingual Educational program (13.403), local education agencies receive assistance to develop and implement new and innovative programs. For the school year 1975-76, bilingual educational services are expected to serve approximately 178,000 children.

Through the Office of Child Development, the Exploring Childhood Program is designed to give high school students an opportunity to learn about many aspects of child development and to interact with children. Originally developed for junior and senior high school students, its adaptation to other settings is being considered. This expansion would involve child care staff and parents as well as young people in a non-school environment. In 1974-75, Exploring Childhood was used in 230 schools and by 410 additional educational and social service agencies.

The following programs have educational components which provide child development and parent education services to specific target populations of adults and youth. The Cooperative Extension Service (10.500) provides these services primarily to persons in rural and farm areas. A related program, Indian Agricultural Extension (15.101), serves Indian organizations and individuals. The Vocational Education-Consumer and Homemaking Program (13.494) is targeted on economically depressed areas or areas of high rates of unemployment, and provides training programs adapted to the needs of youth and adults in these areas.

The Right to Read-Elimination of Illiteracy program (13.533), whose goal is to increase the literacy level of the population, is targeted on persons 16 and older. The program's goal is to increase functional literacy so that, by 1980, 99% of those 16 years of age and 90% of those over 16 will be functionally literate.

The physically handicapped, the retarded, and the disadvantaged all require teachers and staffs able to meet their needs. The Federal government funds several programs (Handicapped Teacher Education, 13.451; Handicapped Physical Education and Recreation Training, 13.448; Teacher Corps-Operations and Training, 13.489; Educational Personnel Training Grants-Career Opportunities, 13.421; and Developmental Disabilities-Demonstration Facilities and Training, 13.632) which train personnel to teach these target populations.

Nutrition

Preliminary findings of the First Health and Nutrition Examination Survey indicate that a substantial proportion of preschool children are inadequately nourished. Data indicate that poor nutrition is found in both Black and White children, and in children in families both above and below the poverty level, especially with respect to iron intake (see Figure 2.7).

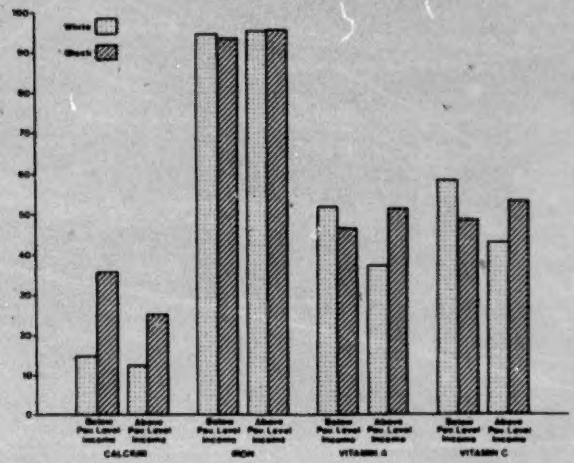


Figure 2.7 Percent Population Aged 1-5 Years Below Nutritritional Standard: 1971 to 1972

This study also suggested that the diets of Blacks and/or children in poverty families include more of certain nutrients per 1,000 calories than those in other groups. For example, Blacks and/or chilchildren from low income families consume more iron, vitamin A, and protein per 1,000 calories than their counterparts. However, the caloric intake of Blacks (both above and below poverty) may be lower than that of Whites, so that certain deficiencies may be more likely among Blacks than Whites.

Four out of every five schools offer the National School Lunch Program (10.555). In FY '74, 24.9 million children, 57% of those enrolled in schools where the program was available, participated in the program (see Figure 2.8). The decline in participation from FY '73 reflects a decrease in school enrollment, rather than any decrease in the rate of participation. This program is not exclusively targeted upon children in poverty families, although free or reduced price lunches (approximately one-third of all school lunches served) are available to children from low-income families.

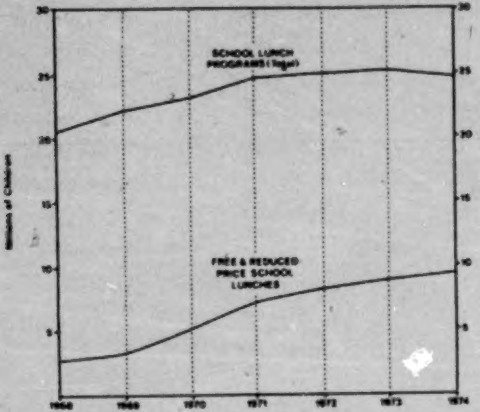


Figure 2.8 Number of Children Participating in the National School Lunch Program: 1968 to 1974

Other programs include the Special Food Service Program for Children (10.552), the School Breakfast Program (10.553), the Special Milk Program for Children (10.556), the Special Supplemental Food Program for Women, Infants, and Children (10.557), Nonfood Assistance for School Food Service Programs (10.554), School Health and Nutrition Services for Children from Low-Income Families (13.523), Child Development-Head Start (13.600), and Follow Through (13.433). There are several programs for improving directly or indirectly the nutritional status of children, particularly those in low-income families: Food Distribution program (10.550), Public Assistance-Maintenance Assistance (State Aid) (13.761), and Native American Programs (13.612). The Food Stamps program (10.551) increases food purchasing power of eligible families; during FY '75 an average of 13.1 million will participate in the program, a 7% increase over FY '73. Nutrition education programs are provided through the Cooperative Extension Service (10.500) and the Indian Agricultural Extension Program (15.101).

Handicapped Children

An estimated 7% of live births, an annual incidence of 200,000, result in handicaps from congenital anomalies, both structural and non-structural (Sickle Cell Anemia, Tay-Sachs Disease). Only about one-third of congenital handicaps are believed to be observable at birth; two-thirds do not become evident until later in life. There are an estimated 1.2 million handicapped children under 6. Between the ages of 0 and 19, approximately 2.3 million children are speech impaired, 2.0 million suffer from learning disabilities, 1.5 million are mentally retarded, 1.3 million are emotionally disturbed, 328,000 are crippled and impaired children, 328,000 children are hard of hearing, 66,000 are visually handicapped and 49,000 are deaf.

The Crippled Children's Services (13.211) provides services, especially in rural and low-income areas, to crippled children and children with conditions which lead to crippling. During FY '74, 509,000 crippled persons under 20, including 97,000 with multiple handicaps and 41,000 with congenital heart disease, were provided services. Maternal and Child Health Services (13.232) provides services to low-income and rural children with physical handicaps, which include screening, diagnosis, treatment, and follow-up services. It seeks to reduce the incidence of mental retardation through improving prenatal and postpartum care of mothers and infants. This program also supports clinics for mentally retarded children which provide diagnostic, counseling, treatment, and follow-up services. Comprehensive services for the mentally retarded are provided through the Developmental Disabilities-Basic Support program (13.630).

Other programs related to handicapping conditions excluding educational programs include Special Food Service Program for Children (10.552), Maternal and Child Health Research (13.231), Maternal and Child Health Training (13.233), Handicapped Early Childhood Assistance (13.444), Handicapped Innovative Programs--Deaf-Blind Centers (13.445), the Office for Handicapped Individuals (13.603), Developmental Disabilities-Special Projects (13.631), Developmental Disabilities-Demonstration Facilities and Training (13.632), and

Handicapped Physical Education and Recreation Training (13.448).

Mental Health

A substantial but unknown number of children have mental health problems; in an unknown percentage of cases treatment is obtained. In 1971, about one-fifth of all patient care episodes in psychiatric services, or 772,000, involved children under 18. Of these, about 632,000, or 82%, were dealt with on an outpatient basis (see Figure 2.9). In the under 18 age group there is little overall difference between Whites and non-Whites in admission rates to outpatient psychiatric services. Males have higher admission rates than females in both groups although admission rates are somewhat higher for non-White than for White males (see Figure 2.10) in the 14-17 age group. Outpatient care was characterized by diagnoses of personality disorders, transient situational disturbances, behavior disorders of childhood and adolescence, and social maladjustment. The 140,000 inpatient episodes involving children under 18 constituted a 32% increase over a two-year period. In addition to the diagnoses associated with outpatient care, inpatient diagnoses were characterized by a relatively high incidence of schizophrenia, depressive disorders, and disorders associated with drug abuse.

Mental Health-Children's Services (13.259) emphasizes prevention of mental health problems and coordination of community services for children and families: 111 and 161 staffing awards were issued in FY '74 and FY '75, respectively. Mental Health-Community Mental Health Centers (13.240) finances the building of centers, organizes and improves mental health services and initially provides partial compensation to professional and technical personnel. Funds for mental health facilities are also provided by Comprehensive Public Health Services-Formula Grants (13.210), Mental Health-Hospital Improvement Grants (13.237), and Mental Health-Hospital Staff Development Grants (13.238). Other programs include Indian Health Services (13.228), Mental Health Fellowships (13.241), Mental Health Research Grants (13.242), Mental Health Training Grants (13.244), Mental Health Research Development Awards (13.281), Mental Health National Research Services Awards (13.282), Medical Assistance Program (13.714), and Public Assistance-Maintenance Assistance (State Aid)(13.761).

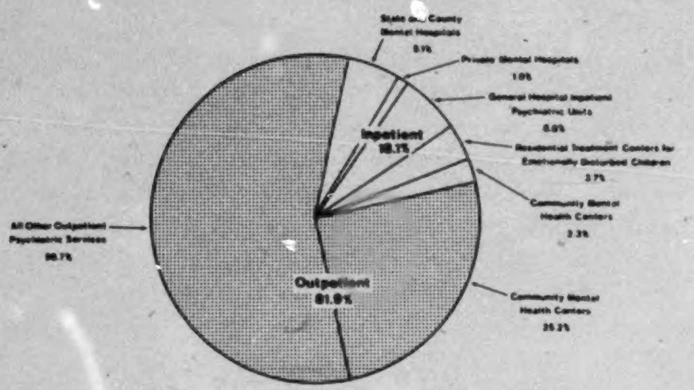


Figure 2.9 Patient Care Epiodes Under 18 Years of Age by Type of Psychiatric Facility: 1971

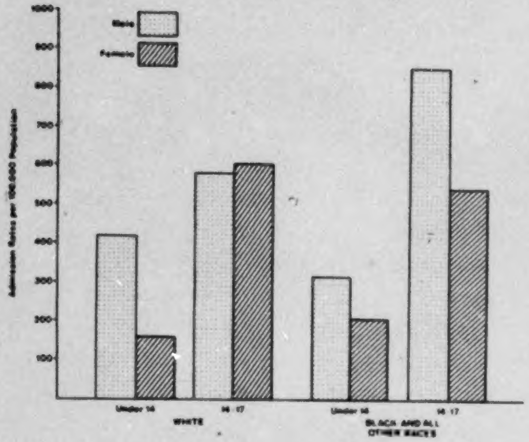


Figure 2.10 Admissions to Outpatient Psychiatric Services: 1970 to 1971

Child Abuse and Neglect

Child abuse and neglect is a multi-faceted problem, with social and legal, as well as physical and mental health implications. To some extent it is a self-perpetuating problem: children who are abused are, in turn, relatively likely to abuse their children. Conservative estimates place the national incidence of parental maltreatment at 60,000, resulting in 6,000 deaths annually--more deaths than are caused by any single childhood disease. Projections from data from California and Colorado indicate that the incidence is much higher. From 200,000 to 250,000 children are in need of protective services each year; 30,000 to 37,500 of them are badly injured. One survey, based on a sample of 129 counties, estimated that 600,000 children under 18 are abused or neglected each year. Florida, which has a relatively effective reporting system, reported over 29,000 incidents of child abuse and neglect between October 1972 and September 1973, a rate of 13.4 cases per 1,000 child population. If this rate is taken as an estimate for the entire U.S., it would place the total at approximately 925,000 cases of child abuse and neglect annually. These estimates vary widely, but due to incomplete reporting all may be on the conservative side.

The Child Development-Child Abuse and Neglect Prevention and Treatment program (13.628) assists State, local, and voluntary agencies in developing and strengthening programs which prevent, identify, and treat child abuse and neglect. Its accomplishments include the establishment of the National Center on Child Abuse and Neglect, the awarding of demonstration and research grants, and the development of a clearinghouse of information related to this problem. Child Welfare Services (13.707) is concerned with protective services which prevent the neglect, abuse, exploitation, or delinquency of children. Financial support may be provided for foster care, adoptive placements, day care, homemaker services, and the return of runaway children. During FY '75 an estimated 222,000 families and 400,000 children received services from this program.

Delinquency, Drug and Alcohol Abuse

Nearly a million children were involved in over 1.1 million juvenile delinquency cases (excluding traffic offenses), representing a 3% increase in 1973 over the previous year. Nine percent of all arrests made in 1973 involved children under 15 and over a quarter involved persons under 18. Juveniles are most likely to be apprehended for larceny-theft (see Figure 2.11). Approximately half of all persons arrested for larceny-theft in 1973 were under 18, representing a 12% increase in rate since 1968.

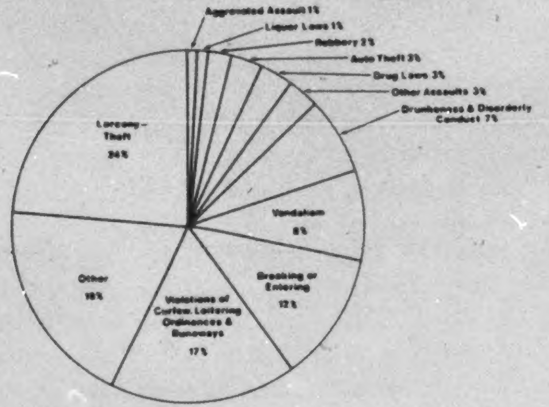


Figure 2.11 Percent Arrests of Persons Under 15 Years of Age: 1973

Violations of drug laws also are likely to involve youthful offenders. In 1973, 57% of all narcotic drug law arrests involved persons under 21 years of age.

Of the approximately 57,000 children in juvenile facilities in 1971, 83% were adjudicated delinquents, 14% were being held pending court action, 2% were dependent and neglected children, and 1% were awaiting transfer to another jurisdiction. Most, about 36,000, were in training schools. The average stay in juvenile correctional facilities has been estimated at eight months. Sixty-one percent of admissions to juvenile correctional facilities were first-time commitments, with males outnumbering females 4 to 1; for recommitments, males outnumbered females 12 to 1.

Children and youth, in addition to perpetrating crimes, are also frequent victims. A recent survey of criminal victimization (see Figure 2.12) indicated that victimization rates are highest between the ages of 12 and 19. Males under 35 were characterized by substantially higher rates than females. By far the most common crime against individuals over 12 is personal larceny, followed by simple and aggravated assaults.

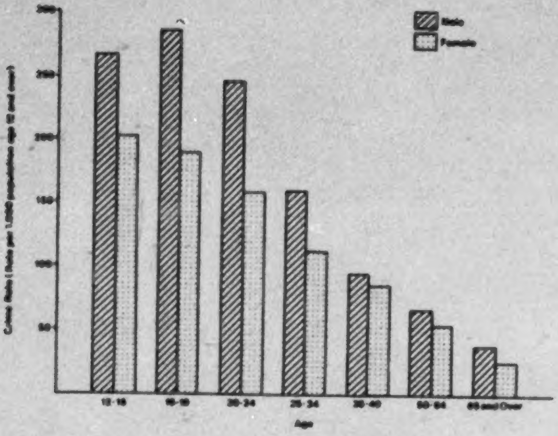


Figure 2.12 Criminal Victimization: 1973

Delinquency prevention is an objective of Child Welfare Services (13.707) which also helps return runaways to their homes. The Office of Youth Development's Runaway Youth Program provides financial assistance to non-profit groups to start new programs or strengthen existing programs for runaways. Educational services are provided to delinquent children through the Educationally Deprived Children in State Administered Institutions Serving Neglected or Delinquent Children (13.431); during FY '75 an estimated 50,000 children in 1,500 institutions participated in this program. The Law Enforcement Assistance Administration is implementing two programs, the first of which is deinstitutionalization of status offenders who have committed no real crime, such as runaways and truants. Begun in early 1975, its goals include removal of status offenders from detention centers, training schools, and jails, and reduction of recidivism. The diversion program, which will involve alternatives to training schools, is expected to become operational during the fall of 1975. Other programs include Mental Health Research Grants (13.242), Mental Health Training

Grants (13.244), Public Assistance-Social Services (13.754) and the National Institute of Mental Health's Center for Studies on Crime and Delinquency.

Use of alcohol is widespread among adolescents and youth. Preliminary findings of the Second Special Report to Congress on Alcohol and Health (1974) indicate that, by 7th grade, 63% of the males and 54% of the females have tried alcoholic beverages; by 12th grade these percentages have climbed to 93% and 87%, respectively. Circumstances under which alcohol is consumed vary: 7th-9th graders may drink at home on special occasions, whereas 10th-12th graders may drink at unsupervised parties. Perhaps 42% of high school students drink at least once a month, and 5% become intoxicated at least once a week.

Other drugs also are used, and abused. Drug Abuse Warning Network data (1973-1974) suggest that children 15 and under comprise 22% of the U.S. population and 7% of the drug-abusing population. However, 16-19 year-olds comprise only 7% of the population, but 24% of the drug-abusing population. A wide variety of drugs are used. The most popular (excluding alcohol) for those 10-19 is marijuana. In the 10-19 age bracket, hallucinogens (notably LSD) are the second most commonly used class of drugs, followed closely by barbiturate sedatives and tranquilizers.

The achievement of psychic effects is the primary motive for drug abuse among those under 20 (see Figure 2.13). Drug usage is primarily related to sex and age. There is little difference between Blacks and Whites in the use of marijuana, which in both ethnic groups seems to be concentrated among males 16-19. Whites who use hashish tend to be under 20, whereas Black users are somewhat older, between 20 and 39. Regardless of ethnicity, males under 29 are more likely than females to utilize amphetamines; females are more likely to utilize other drugs, such as aspirin and phenobarbitol.

The Drug Abuse Education Programs (13.275) collects, prepares, and disseminates drug abuse information; it also develops and evaluates drug abuse education and prevention programs for teachers, laymen, and the general public and, more specifically, youth and special high-risk groups. Children may also benefit from the Children of Alcoholics and the Teenage Alcohol Abuse Prevention programs sponsored by the National Institute on Alcohol Abuse and Alcoholism. Prevention and treatment programs include Drug Abuse Community Service Programs (13.235), Drug Abuse Demonstration Programs (13.254), Comprehensive Public Health Services-Formula Grants (13.210), Narcotic Addict Rehabilitation Act Contracts (13.239), Mental Health-Community Mental Health Centers (13.240), Alcohol Community Service Programs (13.251), Alcohol Demonstration Programs (13.252), Alcohol Formula Grants (13.257), and Drug Abuse Prevention Formula Grants (13.269).

Other programs include Mental Health-Hospital Staff Development Grants (13.238), Alcohol, Drug Abuse, and Mental Health Administration Scientific Communications and Public Education (13.243), Alcohol Fellowships (13.270), Alcohol Research Development Awards (13.271), Alcohol National Research Service Awards (13.272), Alcohol Research Programs (13.273), Drug Abuse Research Development Awards (13.277), Drug Abuse National Research Service Awards (13.278), Drug Abuse Research Programs (13.279), Drug Abuse Training Programs (13.280).

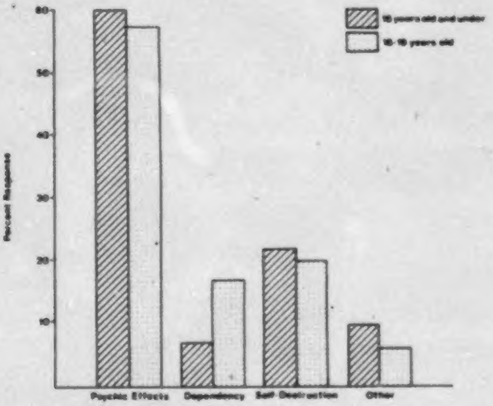


Figure 2.13 Motivation for Abuse of All Drugs Nationwide: July,1973 to February,1974

Physical Health

Physical health problems affecting children and families span family planning, maternal and infant health, and disease control.

Although fertility rates (see Section 1) have been declining steadily over the past several years, overpopulation, unwanted pregnancies, spacing, delay, and limiting family size are still important concerns. There are several Federal programs which provide voluntary contraceptive counseling and services.

Family Planning Projects (13.217) provided family planning services to an estimated 1.6 million people during FY '74, and Maternal and Child Health Services (13.232) provided these services to an estimated 1.25 million (including 115,000 through Family Planning Projects) during the same year. Payments for family planning services are available through the Medical Assistance Program (13.714). Related programs include Family Planning Services-Training Grants (13.260), Population Research (13.864), Comprehensive Public Health Services-Formula Grants (13.210), and Public Assistance-Social Services (13.754).

Although, as discussed in Section 1, both maternal and infant mortality rates have been declining over the past several years, these problems are far from being solved as evidenced, for example, by the discrepancy between the rates for Black and White infants and mothers. In addition, the mortality rate for infants born to teenage mothers is about twice that for infants born to mothers 25 to 34. There are also an estimated 500,000 spontaneous abortions, stillbirths, and miscarriages each year, due to defective fetal development.

Other infants begin life at a disadvantage due to health conditions present at birth. The most common defects observable at birth are genital organ anomalies, followed by anomalies of the heart and circulatory system, muscoskeletal anomalies, and anomalies of the nervous system. However, many birth defects are not observable until later in the child's life.

Low birth weight infants, those weighing less than 5.5 pounds at birth, are seventeen times more likely to die in infancy than infants of normal weight. They are also more susceptible to birth defects. Birth defects afflict about 18% of the 245,000 low birth weight infants born each year, as compared to 6% of infants weighing more than 5-1/2 pounds. A major cause of low birth weight is maternal malnutrition. Moreover, almost one of every four of these infants is born to a teenage mother.

Alcoholic or drug addicted mothers can transmit their problem to their infants. Infants born to these mothers begin life with multiple disadvantages which include the actual physical addiction and subsequent withdrawal, the social implication of an alcoholic or addicted mother, and the possible (but unproven) predisposition to alcohol or drug addiction later in life. Venereal diseases also present threats to the health of infants. Although congenital syphilis is preventable through routine testing and treatment of pregnant women, in 1974 there were 1,334 reported cases of congenital syphilis in the U.S. Despite the downward trend in the incidence of syphilis in the total population (see Figure 2.14) the rate of congenital syphilis in infants under one year of age has increased from .4 (1957) to 1.1 (1973) per 10,000 live births (see Figure 2.15).

Maternal and Child Health Services (13.232) is concerned with all aspects of maternal and infant-child health, including maternal and infant mortality, especially in rural and economically depressed areas. In FY '74 this program provided services to an estimated 142,000 mothers and 48,000 infants, and supported eight intensive infant care projects. Related programs include Family Planning Projects (13.217), Indian Health Services (13.228), and Maternal and Child Health Research (13.231).

There has been a long-term decrease in the incidence of many communicable diseases which are preventable through immunization. As Figure 2.16 shows, fewer cases of measles, rubella, and polio were reported in 1974 than in any year since national reporting began. Figure 2.17 shows trends in immunization. In the early 1970's there was a decrease in polio immunizations, especially in low-income areas. The percentage of school children not immunized against polio reached its highest level since 1965. Although there was an increase in immunization against rubella between 1970 and 1972, the number of doses administered through public programs dropped by about 30% during the following year. Also, the number of doses of measles vaccine administered through public programs fell during this period, though by a smaller percentage, about 16%. Decreased emphasis on mass immunization and community programs resulted in inadequate immunization in poverty areas; efforts are being made to re-emphasize mass immunization programs. Mass immunizations against communicable disease are administered by Disease Control-Project Grants (13.268) with priority given to areas and populations with the highest incidence and prevalance of communicable diseases; $6.2 million was expended for this purpose in FY '75.

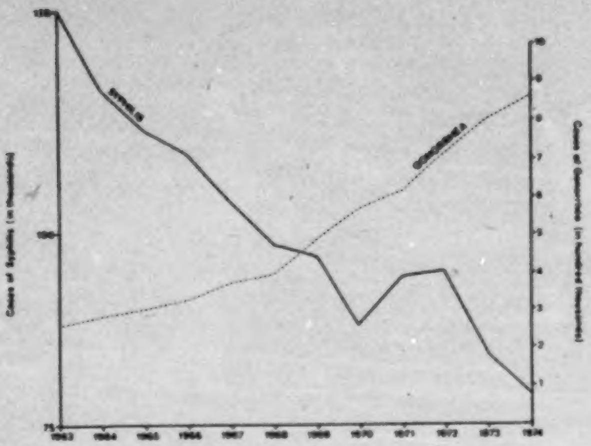


Figure 2.14 Reported Cases of Venereal Disease: 1963 to 1974

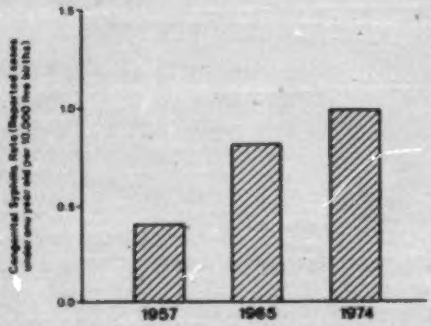


Figure 2.15 Congenital Syphilis: 1957, 1965, 1974

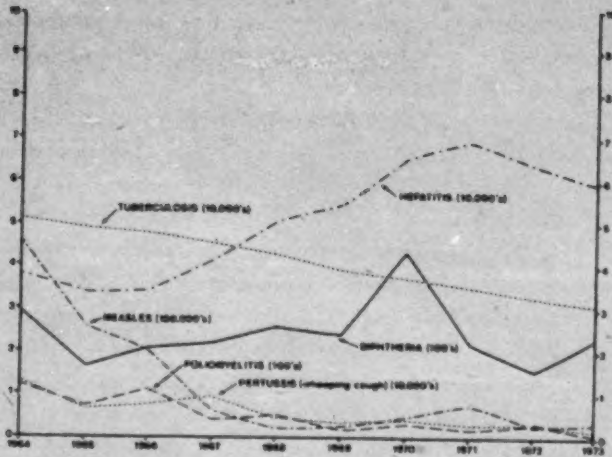


Figure 2.16 Reported Cases of Selected Communicable Diseases in the United States: 1964 to 1973

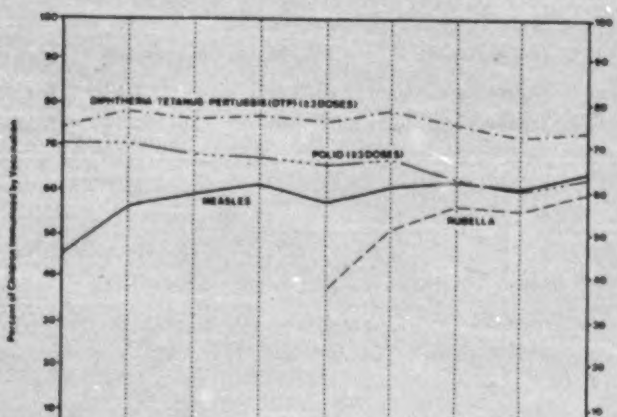


Figure 2.17 Major Immunizations for Children 1-4 Years Old: 1966 to 1974

Well-child clinics, pediatric clinics, immunization programs, and dental care projects are provided to children from low-income families by Maternal and Child Health Services (13.232). Family Health Centers (13.261) also provide low-income recipients with comprehensive health services; an estimated 105,000 people will receive services from its 30 projects.

Programs such as Indian Health Services (13.228), Migrant Health Grants (13.246), and the Appalachian Health Demonstrations (23.004) administer comprehensive health services to specific target populations.

The Early Periodic Screening, Diagnosis, and Treatment Program is a part of the Medical Assistance Program (13.714). Between February 1972 and September 30, 1974, approximately 1,881,000 children under 21 received services from the EPSDT program. The Center for Disease Control-Investigations, Surveillance, and Technical Assistance (13.283) will test 300,000 children in 35 to 40 project areas for poisoning from lead-based paint. This condition, a threat to children exposed to lead-based paint, is the focus of the Childhood Lead-Based Paint Poisoning Control program (13.266); an estimated 490,000 high-risk children were screened in FY '75. Of these children, approximately 73,000 had elevated blood levels and 24,800 children were treated. In addition to screening and treating children, this program provides for inspection of dwelling units of these children and subsequent reduction of the paint hazard. In FY '75, approximately 21,000 homes were inspected, with hazard reductions accomplished in 9,500 units. The Urban Rat Control program (13.267) seeks to reduce health threats from rat infestations.

Other programs related to child health include Health Services Development-Project Grants (13.224), Office for Health Maintenance Organizations (13.256), Emergency Medical Services (13.284), Public Assistance-Maintenance Assistance (State Aid)(13.761), Maternal and Child Health Research (13.231) and Child Health Research (13.865).

3

Targeting of Programmatic Resources

Indices of Developmental Risk

In preceding sections of this report we presented a variety of demographic, programmatic, and descriptive statistics. The data were selected from a vast spectrum of cradle-to-grave statistics which begins with the Standard Live Birth Certificate and ends with the Standard Death Certificate. The first problem was the selection of those most useful for descriptive purposes. A second problem was to identify statistics that could be distilled into comprehensive, valid measures applicable to a variety of program and planning purposes.

Our approach was to utilize available data to (1) attempt to develop normative indices of health and educational risk, considering these to be salient dimensions of developmental risk, and (2) to demonstrate the interpretation and utilization of these indices. The methodology used was originated by Snapper, O'Connor, and Einhorn (1974), and is based upon decision-theoretic concepts. (Copies of that paper, and the data used in developing indices and documentation are available upon request.) Briefly, the procedure was to make an initial judgment about which variables were conceptually relevant to each index and then using a statistical technique, factor analysis, to determine which variables were most valid as index components.* Extensive analyses indicated that the variables shown in Tables 3.1 and 3.2 are relevant to the respective indices. (A larger number of variables could have been used, but

Table 3.1 Health Index Variables

H_1: Infant deaths, per 1,000 live births.

H_2: Children under 5 per 1,000 women age 15-17.

H_3: Percent of families with children under 6 in which neither parent has graduated from high school.

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*This procedure should be carefully distinguished from conventional sociological uses of factor analysis, for which wholly demographic variables are appropriate. For example, Census Use Study (1971) obtained a factor interpreted as socio-economic status; a similar factor, "Disorganized Poverty", was obtained by Kogan and Jenkins (1974). Procedures used in those studies are different from those proposed by Snapper, O'Connor and Einhorn for the development of normative indices. For purposes of deriving normative indices demographic variables, such as income and ethnicity, are typically inappropriate.

Table 3.2 Education Index Variables

E_1: Percent draftees failing to meet mental requirements.

E_2: Percent of persons 16-17 enrolled in school.

E_3: Percent of persons 14 and over that are illiterate.

E_4: Percent of persons 20-24 with no formal schooling.

these additional variables had trivial impact on the composite and were excluded.)*

In addition to aiding in the selection of relevant variables, factor analysis is commonly used to derive a statistical composite. Health and Education Scores are thus composites of the variables shown in Tables 3.1 and 3.2, respectively. Scores were standardized to the 0-10 interval, where 10 indicates maximum developmental risk.

Since the concepts and dimensions of developmental risk are inherently subjective and normative, it is necessary to validate judgmentally Health and Education Scores. Figures 3.1 and 3.2 show the relationship between judgments about relative health and educational risk and operationalized Health and Education Scores. Essentially

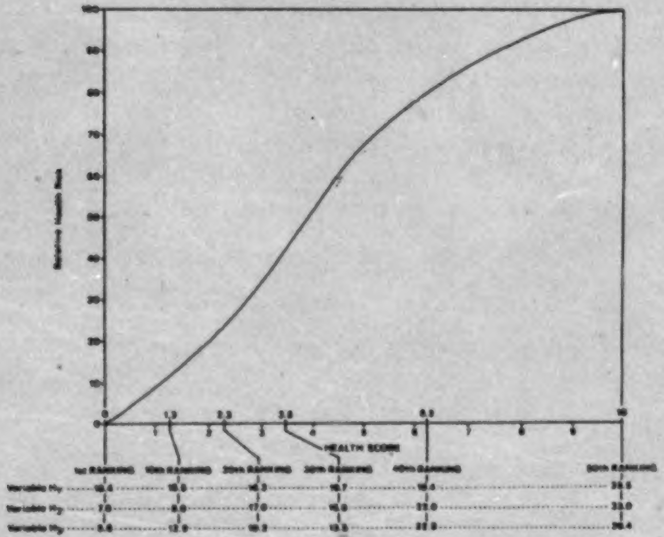

Figure 3.1 Health Risk as a Function of Health Score

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*For example, low-birth weights, per 1,000 live births, could have been included as a fourth variable in the health index. However, it had a relatively low loading, .62, and was therefore excluded.

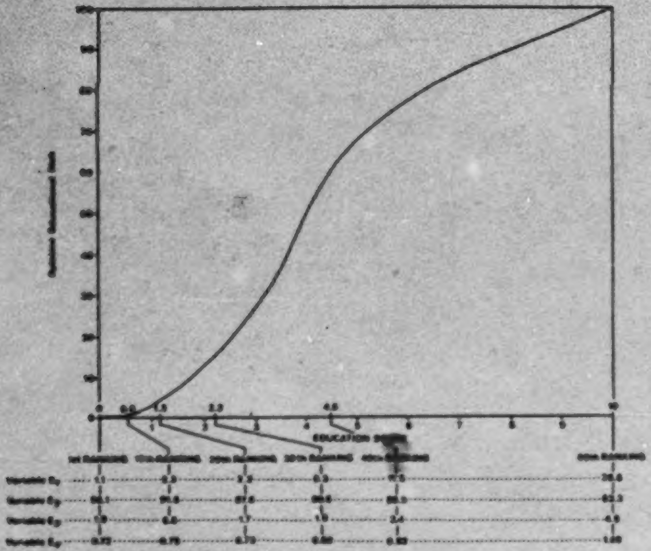

Figure 3.2 Educational Risk as a Function of Education Score

value judgments, ratings were made by an expert in child development familiar with scaling techniques and analysis. The values 0 and 100 (on the vertical) are numerically arbitrary, but represent minimum and maximum perceived risk. Of course, small differences should not be taken seriously, in part because the statistics for each State are essentially estimates, and in part because the shapes of the functions might have been slightly different, had ratings of a different expert been used.

The importance of Figures 3.1 and 3.2 is that they indicate a systematic relationship between conceptual dimensions of developmental risk and the Health and Education Scores. Thus, they indicate that the Health and Education Scores are valid measures and justify their use in further statistical analyses, exploring the correlates of developmental risk.

Geo-Distribution

Data used for developing indices were State totals, and scores pertain to individual States as the unit of analysis. Figures 3.3 and 3.4 provide an indication of gross geographic concentrations of

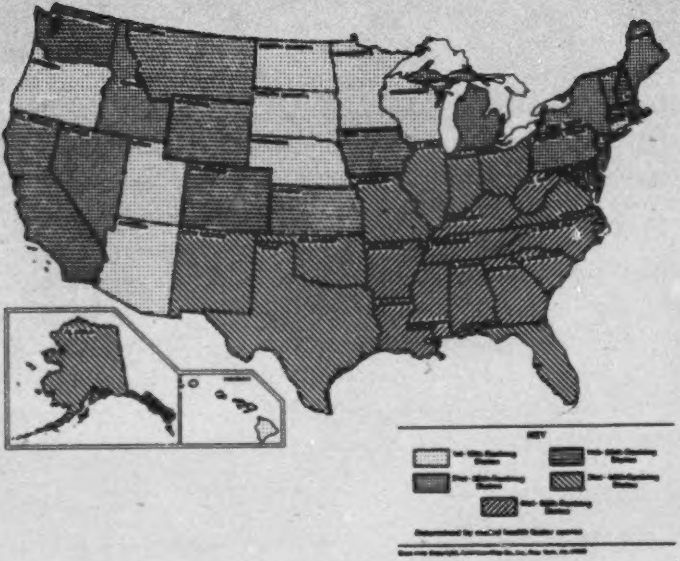

Figure 3.3 State Ranking by Health Score

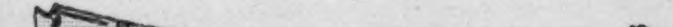

Figure 3.4 State Ranking by Education Score

risk. These are based upon the Health and Education Scores and groups of 10 States, from lowest to highest Scores. Although the differences both within and between groups of States are sometimes small, Figures 3.3 and 3.4 indicate some geographical patterns. There is a tendency for health and educational risk to be greatest in the southern portions of the country, particularly the southeast. Note however that there appear to be some differences in geo-distribution between health and educational risk. Comparing Figures 3.3 and 3.4 suggests that some midwestern States may be relatively high in health risk, as compared to the educational risk in those States. Some States, especially in the central and northern portions of the country, seem to be relatively low in terms of both education and health risk, as indicated by Figures 3.3 and 3.4.

Relationship to Demographic Variables

During the preparation of this report, approximately 50 variables were identified that potentially would be relevant to indices of developmental risk. Of these, none was a wholly demographic variable. Nevertheless, demographic variables are often used (or misused) for a variety of purposes. A controversial use of demographic variables is as surrogate measures, when more normative measures or indices are unavailable. For example, programs may focus upon health or educational problems, but demographic variables are used to define target populations or to establish eligibility criteria. In conjunction with family size, income is used to determine poverty versus non-poverty status--poverty status being a criterion of eligibility in many programs. Ethnicity is also used as an eligibility criterion. For detailed analyses, we chose Percent Poverty and Percent Black because of the prevalence of their use.

In analyses involving these demographic variables, we will not consider how good, in an absolute sense, each is as a programmatic criterion. Clearly, existing criteria could be improved: for example, criteria involving income could be adjusted for regional or local cost of living, much as they are adjusted for family size. The crucial question is: how much more efficiently could resources be targeted, using normative rather than surrogate measures? The usefulness of surrogate measures for this purpose depends in part upon their statistical relationship to normative measures.

The correlations between Percent Poverty, Percent Black, and Health and Education Scores are given in Table 3.3. Throughout this section $\underline{r}^2$, a more meaningful statistic than the unsquared correlation coefficient, will be reported in parentheses, following the correlation coefficient. The correlation coefficients are exaggerated by the extreme endpoints, i.e., the States with either very high or low Health (or Education) Scores. There is a tendency for States with relatively high Health or Education Scores to be concomitantly high in terms of Percent Poverty or Percent Black. However, the relationship is far from perfect. In particular, there is great variability in both Health and Education Scores, throughout the ranges of the demographic variables.

Table 3.3 Correlation Coefficients

	Health Score	Education Score	Percent Poverty	Percent Black
Health Score	1.00 (1.00)	.86 (.74)	.80 (.64)	.80 (.64)
Education Score	—	1.00 (1.00)	.81 (.66)	.85 (.72)
Percent Poverty	—	—	1.00 (1.00)	.65 (.42)
Percent Black	—	—	—	1.00 (1.00)

Relationship Between Health and Educational Risk

What is the statistical relationship between Health and Educational Scores? As Table 3.3 shows, it is high; the correlation coefficient is .86 (.74). Figure 3.5 illustrates this relationship for individual States.

In view of the high correlation between Health and Education Scores a number of analyses were performed.* Although these analyses could not indicate that the same subpopulations within States were at both health and educational risk, they did explore correlates that might otherwise "explain" the relationship indicated in Figure 3.5.

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*The first such analysis was to eliminate variable H_3 from the Health index. Variable H_3, nominally an educational measure (though nevertheless relevant to health risk), might have artifactually induced this inter-index relationship. However, dropping H_3 from the index made virtually no difference in the correlation between the two indices. That is, the high correlation between the two indices is not a statistical artifact, due to the inclusion of H_3 in the health index.

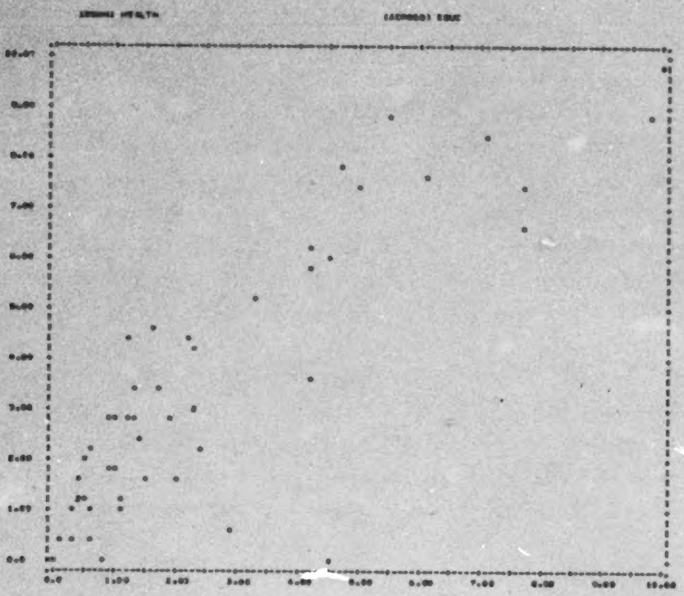


Figure 3.5 Health Score by Education Score

Partial correlations were used to assess the contribution of variables to this inter-index relationship. A number of sociological and demographic variables, many of which were suggested in Redick, Goldsmith, and Unger (1971) in addition to Percent Poverty and Percent Black, were incorporated into the analyses. Findings were of three general kinds. First, most variables did little to reduce the correlation, or otherwise produced results difficult to interpret. Second, certain income measures correlated highly with Percent Poverty, and therefore are statistically interchangeable with that variable. Third, Percent Black contributed to the relationship in Figure 3.5, apart from the economic variable. That is, both Percent Poverty and Percent Black emerged as salient variables, in that each contributed to the relationship shown in Figure 3.5.

Recall that the (zero-order) correlation between Health and Education Scores was .86 (.74). Controlling for Percent Poverty yielded a partial correlation coefficient of .59 (.35). Further, simultaneously controlling for Percent Black and Percent Poverty yielded a partial correlation coefficient of .26 (.07). One index accounts for only about 7% of the variance in the other, implying that Percent Poverty and Percent Black can almost totally account for the relationship between Health and Education Scores.

A related finding emerges from analyses involving Percent Black and each of the indices. Consider the correlation coefficients shown in Table 3.3 and the scatterplots relating Health and Education Scores to Percent Black. Part of this statistical relationship can be explained by economic variables: controlling for Percent Poverty yields partial correlation coefficients of .62 (.38) and .74 (.55) between Percent Black and the Health and Education Scores, respectively (as compared to zero-order correlation coefficients of .80 and .85). Thus, Percent Poverty does not fully explain the relationship between Percent Black and the index Scores. (Similar analyses indicated that Percent Black did not fully explain the relationship between Percent Poverty and index Scores.)

Two caveats must be emphasized. First, present analyses were based upon State totals, and our Findings may not be replicated when we use small-area statistics. Second, the fact that demographic variables enter into statistical relationships in no way implies "causality"--particularly in the case of ethnic variables. For example, Percent Black is nominally an ethnic measure: but equally well may be interpreted as a measure of degree of poverty, availability and adequacy of services, isolation, inequities in service delivery, socio-economic status of parents, opportunities, and so on. Ethnicity *per se* is unlikely to be a fundamental ingredient in any of the statistical relationships examined in this report. Moreover, Percent Poverty is not a particularly good variable for portraying the economic status of a population.

Why Develop Indices of Developmental Risk?

The purpose of indices of developmental risk is to identify populations of children that are at relatively high risk. However, a common practice is to define target populations by one or more demographic variables. How suitable are these demographic variables as surrogate measures of developmental risk? One might argue that income and developmental risk are so intimately related that resources can be targeted using demographic definitions of program populations. Our position, however, is that statistical relationships are neither strong enough nor sufficiently systematic to justify their use as a surrogate. Analyses using our indices, based upon State totals, are illustrative of the deficiencies of the surrogate measure approach.

Correlations between demographic variables and Health and Education Scores are .80, or slightly higher. Statistically, this relationship is significant. But, does statistical significance imply that Percent Poverty (or Percent Black) is a viable criterion for allocating health and educational services? Consider Figures 3.6-3.9. Choose an arbitrary level of Percent Poverty (or Percent Black), and read vertically to find the associated Health (or Education) Score. Usually, there will be one or more States with a lower Percent Poverty (or Percent Black) and a higher Health (or Education) Score. The number of such classification errors indicates how good--or how bad—the demographic variable is as a criterion.

However, Figures 3.6-3.9 really indicate the best one can do, using demographic variables as surrogate criteria. The use of State totals greatly restricts the range of Health or Education Scores associated with any given level of a demographic variable. But criteria for programmatic and policy decisions must be applicable to much smaller units, often no larger than counties or submetropolitan areas. Use of county rather than State totals would greatly increase the range of Health or Education Scores associated with any given level of a demographic variable, i.e., there would be much more vertical dispersion in figures analogous to 3.6-3.9. Such increases in range would imply a dramatic increase in the number of classification errors--which would approach chance rates in the limiting case. Thus, the use of demographic variables as surrogates becomes increasingly suspect as the unit of analysis becomes smaller, even if correlations based upon State totals are very

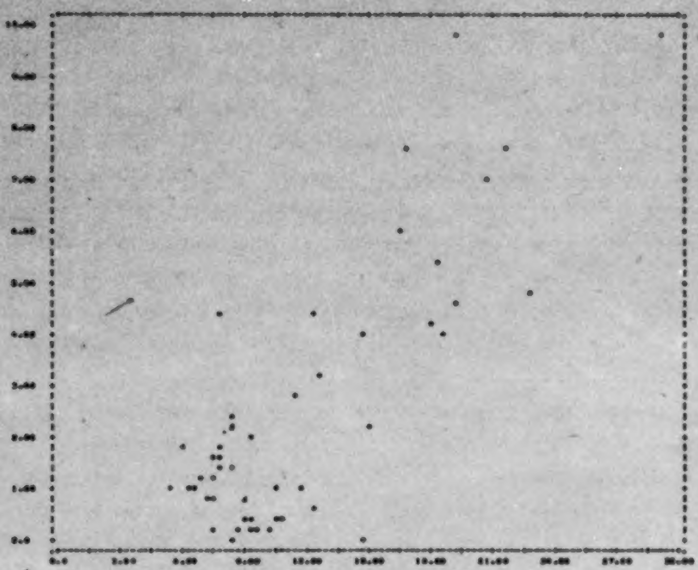


Figure 3.6 Education Score by Poverty

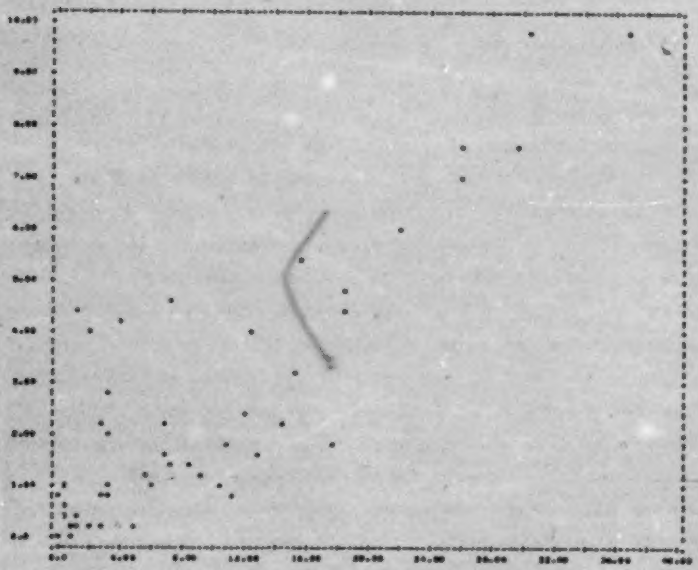


Figure 3.7 Education Score by Percent Black

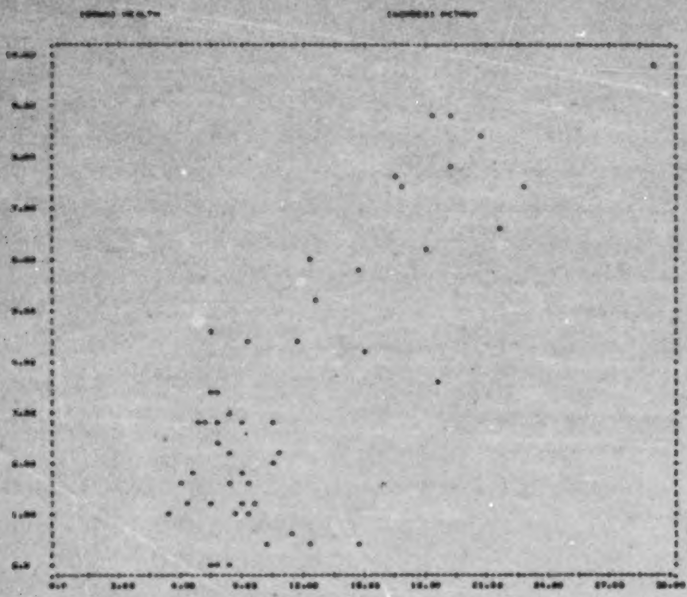


Figure 3.8 Health Score by Poverty

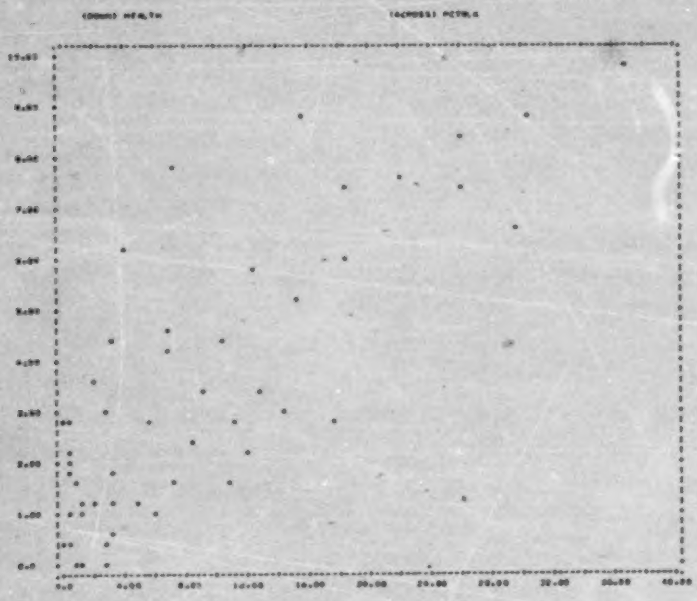


Figure 3.9 Health Score by Percent Black

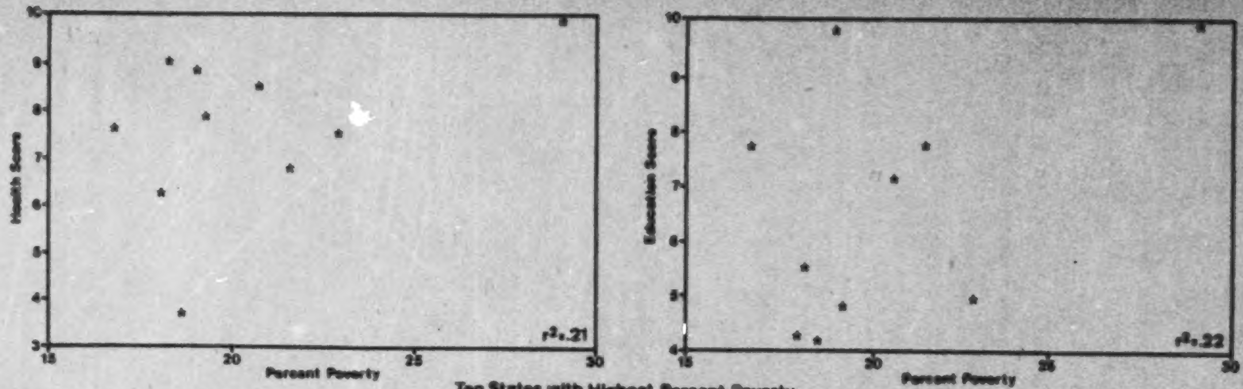
high.

Another problem with demographic criteria is that, once they are used to define the total eligible population, they are of little or no use in selecting sub-populations. Typically, programs do not serve all persons technically defined as eligible, and it is unrealistic to expect an expansion of programs in order to serve all these persons. Moreover, program cutbacks may force a reduction in the number of persons served. Thus there is a _de facto_ selection of program beneficiaries which is often opportunistic, on a first-come, first-serve basis. Ideally this process would not be capricious, and decisions about priorities would be based upon normative measures of need.

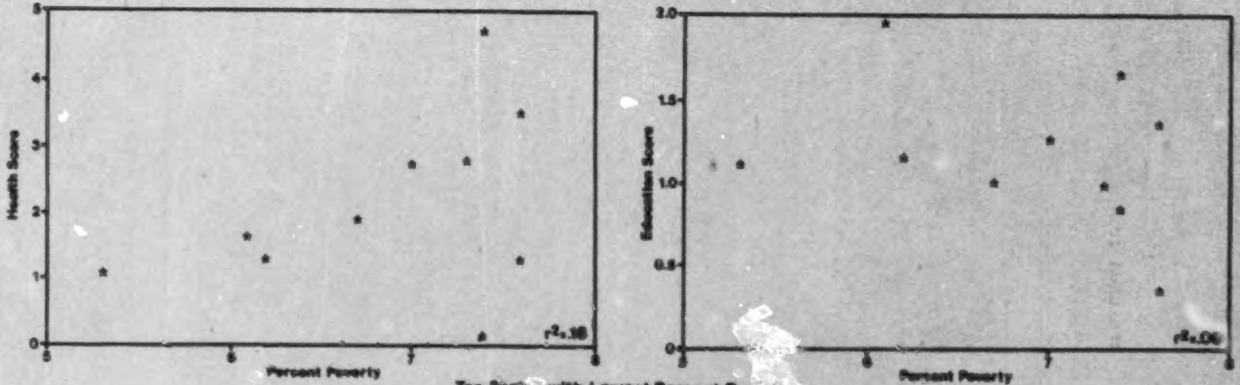
The statistical problems that arise when sub-populations are relatively homogeneous are illustrated in Figure 3.10. Data are shown for the 10 States with the highest Percent Poverty, and for the 10 States with the lowest percent poverty. These data were chosen because they are relatively homogeneous with respect to demographic variables, compared to the nation as a whole. Extreme endpoints may yield non-zero correlation coefficients but, clearly, these figures do not reflect strong or consistent relationships. As mentioned earlier, whatever relationships appear in these figures would further evaporate if smaller geographical units (e.g., counties) had been used.

An implication is that use of demographic variables invites systematic errors in the targeting of resources. Suppose, for example, that there are several candidate sites for programs targeted on developmental risk. If demographic characteristics are used to define eligibility, areas which do not conform to the demographic stereotype, but which are in fact areas of high developmental risk, will be systematically ignored. For example, children in an area where Percent Poverty is high may be less at risk than children in another area, where Percent Poverty is lower. State programs, the way programs are administered within States, differences in cost of living, or accessibility of services may render demographic criteria incomparable in terms of the associated degree of developmental risk, and therefore as programmatic criteria.

How can the targeting of child and family services and pro-



Ten States with Highest Percent Poverty



Ten States with Lowest Percent Poverty

Figure 3.10 Correlations Within Subpopulations

grams be improved? Our analyses do not contradict the contention that developmental risk is associated to some extent with certain demographic subpopulations and should not be used to support arguments for elimination or reduction of current programs targeted on those populations. But they also suggest that normative measures or indices of developmental risk are better criteria for targeting of resources. Through their use, sub-populations at greatest developmental risk could be more readily identified, particularly the at-risk populations that do not conform to demographic stereotypes.

Problem Identification and Service Provision

Programs have at least two important functions. One is the identification of children at developmental risk, in need of services provided through a program. A second is the provision of services, either of a preventive or remedial nature. Identification pertains to determining which geographic areas are at high-risk, such as the identification of areas where the incidence of communicable diseases is high, or the identification of developmental problems or needs in specific individuals. Once a need or problem is identified, appropriate services may be rendered, or referrals to other programs may be made. If the family is ineligible for such programs, it may be advised to seek professional assistance from private sources.

Because these functions are both important and logically distinct, it is useful to examine them separately.

Identification

How are persons at risk or in need of services identified? Many programs have a diagnostic component or other mechanism for assessing needs. However, these often pertain only to those persons enrolled in a program—which implies that needs are most likely to be identified in persons eligible for the program. In other instances, needs may be identified for geographic areas, but sites (rather than individual persons) must satisfy certain criteria. Thus, the demographic characteristics of the child's family, and the geographical area in which the family lives, affect the likelihood that a child's developmental needs or problems will be identified. Some illustrative examples are discussed below.

Estimates suggest that a substantial majority of mental health problems are neither identified nor treated. Problems of mental health are found in all groups, regardless of age, ethnicity, income, and sex. In most instances, identification is pursuant to enrollment, often through self-referral, and is therefore predicated upon eligibility. For children, this means that mental health problems such as emotional disturbances are least likely to be identified among young children, especially preschoolers; parents may not detect the problem, they may not live in an area served by a program, and they are too young to be identified through a school-based program. Moreover, the existence of a local program does not ensure identification of mental health problems. For example, Community Mental Health Centers are not specially targeted upon children, and there is of course no means for screening the general population for mental health problems. Redick, Goldsmith, and Unger (1971) have proposed an analytical method for identifying areas with high-risk populations, using demographic variables available through the decennial Census.

In the preschool years, impediments requiring specialized education services are most likely to be identified in those who are eligible for, and enrolled in, preschool programs. For the majority, the need for child development programs becomes apparent only after the child is enrolled in primary school--after the opportuity to benefit from preschool programs has passed. Enrollment is often, though not always, limited to children of low-income families, those of specific ethnic groups, or those who live in areas served by child development programs (e.g., Appalachian Child Development).

Measures of educational outcomes have been suggested; as examples see Mushkin (1973a and 1973b). However, typical educational indicators pertain to measuring the "output" of educational systems, and are only marginally relevant to identifying groups at educational risk, which would benefit from preschool educational programs.

The need for child care arrangements depends upon several variables, including the involvement of mothers in the labor force. Census Use Study (1974) has proposed a methodology for identifying sites where the demand for day care is high, but the supply is low.

As we have seen, poor nutrition is found in all groups, and certain types of deficiencies seem to be quite common. Identification of inadequate nutrition is most likely through health programs (such as Medicaid or well child clinics) rather than through nutritional programs, which typically have no identification or screening component. Health surveys involve far too small a sample to identify more than a tiny fraction of inadequately nourished children. Thus, poor nutrition is most likely to be detected in those who are eligible for certain programs--such as persons from low-income groups--or those with private family physicians.

Health programs vary considerably in how needs are identified. Immunization programs, for example, may be targeted upon areas with a demonstrable need--such as high incidence of communicable disease. Medicaid is charged with screening eligible children--those from poverty families, or near-poverty families who are defined as "medically needy". In contrast, Health Maintenance Organizations are targeted on geographic units identified as "medically underserved areas", regardless of whether they are low-income. Such areas are identified through the use of an index of medical underservedness. However, that index includes Percent Poverty as one of its four variables, and low-income areas are likely to be identified as high-priority sites.

Provision of Services

Although there is a tendency for programs to identify needs and problems in low-income families and areas, provision of services is not always restricted to low-income persons and areas. Nevertheless, once a need is identified, financial considerations affect the delivery of services. In the majority of instances, the family is financially able to obtain services from private sources, for which it bears the entire cost. In other instances the costs of services are so high that even middle-income families cannot pay for them. In such instances, services may be provided through public programs, either free or at a rate dependent in part upon family income. In other instances, the family may simply be ineligible regardless of its needs and its inability to pay for services. Of course, the demand for publicly supported services invariably outstrips supply, and the important issue becomes the establishment of priorities. In the examples discussed below there are important and difficult questions about who should be provided what type of service, and at what cost.

Availability of child care highlights the issues. There is a shortage of suitable child-care arrangements, and those programs at least partially supported by Federal funds are tightening eligibility requirements, based on income. Thus, there is a fairly broad income range in which a working mother would not be able to afford quality child care--but would be ineligible for free or subsidized care. Of course, child care is sought for a variety of reasons, other than enabling parents to work. There may be genuine needs for child care that go unmet, while care is provided on a first-come, first-served basis.

Substantial numbers of handicapped children require costly long-term care and services. An unknown but potentially large number of these children are in families whose incomes are above the allowable level for public programs, but below the amount needed to pay for services through private sources. The school system is a vehicle for providing services to many handicapped children, but not all such children receive services, despite the fact that they may be technically eligible. As school budgets shrink, or are eroded by inflated costs, it is likely that the number of children served will shrink, or that the quality of services will deteriorate. Overall, priorities in the provision of services seem to require clarification.

Health care programs differ considerably in terms of costs associated with the provision of services. Low-income children in the Medicaid program are eligible for a variety of services, provided without cost to the family. The Federal share of Medicaid costs, however, depends upon the per capita income of States. Although Health Maintenance Organizations are not specifically targeted upon children, unlike portions of the Medicaid program, they are important because they are targeted upon medically underserved areas and, therefore, may be the only readily available medical facilities. This program does not utilize a fee structure that is contingent upon family income, but charges fixed fees for office visits and for monthly subscription. Practices typically vary by State, and in some instances monthly subscription fees may be paid by an outside party (notably Medicaid). Thus it is likely that many families, especially those of low-to-moderate income who do not receive public assistance or who otherwise are not defined as "medically needy", are unable to afford certain costly, but necessary, medical services for their children.

Conclusions

It is difficult to assess the overall efficacy of Federal programs, and their impact upon problems of child development. Part of the difficulty stems from the lack of valid measures of the extent and degree of problems, as well as a lack of sensitive measures of program impact. Part of the difficulty also arises from the bewildering tangle of Federal programs, objectives, implementation modalities, target populations and eligibility requirements. There are often multiple programs administered by different agencies--although they impinge upon closely related problems and needs. Any given program is likely to be multi-objective, and may utilize any of a number of implementation modalities such as: provision of technical assistance, direct payments, supportive services, and subsidies. An additional complication is that target populations and eligibility requirements may be variously defined as all persons (adults included) living in a particular area, persons of a specific ethnic group, persons in particular types of institutions, persons within a specified age group, persons below poverty, and the like. Moreover, States often have a hand in administering programs, so that such data as are available may not be comparable across States.

What about the problems of developmental risk identified in this report? How effectively are they being addressed? Usually there is at least one program or agency whose objectives encompass any given need or problem. But our impression is that resources are diffusely spread across many problems and needs, and that these resources are extremely limited. This situation is likely to be aggravated by continued high unemployment and the increasing incidence of low-income, single-parent families, which effectively increase whatever shortfall there is between demand and supply. Such fiscal constraints underscore the importance of targeting resources as effectively as possible.

Within the context of existing programs, programmatic resources could be allocated both more effectively and more equitably. We believe that in many instances—though certainly not all--it is both unnecessary and inappropriate to focus programs exclusively upon demographically-defined groups. Problems seem to arise from the supposition that eligibility criteria do double duty. First, they are assumed to designate populations in which needs are greatest. Second, they limit the number of eligible persons by targeting on those whose ability to pay happens to be least. We do not find fault with such criteria because they include the poor and minorities: but they are useless for identifying subpopulations of these groups when resources are limited and they arbitrarily and systematically exclude others.

The fundamental reason most eligibility criteria are inappropriate, we believe, is that problems of developmental risk are not conveniently confined to any demographically-defined group--a point we have emphasized throughout this report. They are more suited for measuring ability to pay rather than for identifying populations that are in fact at greatest developmental risk. The use of such criteria creates inequities; for example, families just above the poverty cutoff may have greater unmet needs than poverty families, who are eligible for Federal programs. The evidence is largely anecdotal, but there are numerous instances in which children in non-poverty families require services their families cannot afford, which would be provided to families below poverty. Such inequities illustrate the importance of assessing the needs of children independently of a family's income.

An alternative to current practices is to utilize two separate measures: one reflecting the extent or severity of a problem, the other reflecting ability to pay. We have already discussed how statistics may be incorporated into measures of developmental risk. Although such indices might vary from program to program, either because better geographic resolution or more specific measures are needed, suitable indices could be developed using existing data sources. The health index discussed in this report might, for example, be useful for selecting high-risk sites for comprehensive health programs, whereas a simpler index (e.g., measures of immunization rates) might be adequate for a program more exclusively focused upon immunization. In many instances individual variables might be satisfactory measures; in such cases optimal allocation might be possible using straightforward decision-theoretical techniques. Regardless of how appropriate measures are developed, the implication is that program sites or populations would not be restricted to those compatible with a demographic stereotype. Across sites, the common characteristic would be high risk--the populations would usually be diverse with respect to demographic characteristics.

Because ability to pay would therefore vary widely across sites it would, in the interest of equity, be appropriate to use sliding fee schedules, based jointly upon family income and the cost of services or treatment provided. Children from families with moderate incomes would be served, although these families would normally pay for some or all costs. Such a schedule would continue to expend the bulk of monies upon those least able to pay, but concomitantly would maximize the number of problems identified and treated.

The Food Stamp program is illustrative about how needs and ability to pay might be separated. First, it serves non-poverty as well as poverty families, and uses a sliding fee schedule to adjust for differences in income. Second, the goal of the program is to ensure adequate nutrition, by supplying coupons exchangable for food goods. In the past, determination of needs was based upon food quantities for a "standard" four person family. However, a recent court decision indicated that the program was systematically failing to meet the needs of certain families--notably large families or those with several children. Accordingly, the Department of Agriculture is exploring ways to reallocate resources, to better meet the needs of these families. The new allocation rules should be more sensitive to the needs of individual families, which depart from the "standard" type of family. It is of course precisely this type of retargeting that we think is important, and for which we recommend normative approaches.

We should note that some agencies are already developing indices, for a variety of purposes. To us, such efforts seem entirely appropriate, and represent important steps towards allocating resources in a more effective and equitable way than is possible using typical eligibility criteria.

4 Appendices

Appendix 1

Tables

Table 1.1 Population in Metropolitan Areas: 1974

	All Races		White		Black and All Other Races	
	Number	Percent	Number	Percent	Number	Percent
Total	208,105*	100.0	181,503*	100.0	26,602*	100.0
Metropolitan Areas	142,223	68.3	121,875	67.2	20,347	76.5
In Central Cities	61,836	29.7	46,758	25.8	15,078	56.7
Outside Central Cities	80,386	38.6	75,117	41.4	5,269	19.8
Nonmetropolitan Areas	65,882	31.6	59,628	32.9	6,255	23.5

*In thousands in specified populations.

Data are based upon April-centered annual averages from the Current Population Survey.

"Metropolitan population" refers to persons dwelling in the 243 Standard Metropolitan Statistical Areas in 1970. Data for central cities refer to boundaries as of January 1, 1970.

Source: Bureau of the Census. Population Profile of the United States: 1974. Table 15.

Table 1.2 Fertility Rates: 1965-1973

	All Races	White	Black	Black And All Other Races
1965	96.6*	91.4*	133.9*	133.9*
1966	91.3	86.4	125.7	125.9
1967	87.6	83.1	119.7	119.8
1968	85.7	81.5	114.0	114.9
1969	86.5	82.4	113.6	114.8
1970	87.9	84.1	115.4	113.0
1971	81.8	77.5	110.1	109.5
1972	73.4	69.2	100.5	100.3
1973	69.2	65.3	94.3	94.3

*Registered births per 1,000 women 15-44 years of age in specified groups.

1965, 1966, 1968, 1969, 1970, and 1971 data are based upon 50-percent samples. 1972 and 1973 data based upon 50- to 100-percent samples; data for 1967 are based upon 20- to 50-percent samples. 1970-1973 data exclude births to non-residents of the United States.

Source: National Center for Health Statistics. Summary Report: Final Natality Statistics, 1973. Table 1.

Table 1.3 Leading Causes of Death Among Infants and Children: 1970

	Number of Deaths	Death Rate
Under 1 Year Old (All Deaths)	74,667	2,127*
Anoxia	19,963	569
Congenital Anomalies	11,259	321
Complications of Pregnancy and Childbirth	10,473	298
Immaturity	8,752	249
Pneumonia	6,220	177
Accidents (Total)	2,294	65
Ingestion of food, object	705	20
Mechanical Suffocation	567	16
Motor-Vehicle	343	10
Fires, Burns	135	4
Falls	135	4
Other	409	11
1 to 4 Years Old (All Deaths)	11,548	85
Accidents (Total)	4,300	32
Motor-Vehicle	1,572	12
Drowning	800	6
Fires, Burns	713	5
Falls	205	2
Ingestion of food, object	201	1
Other	809	6
Congenital Anomalies	1,331	10
Cancer	1,027	8
5 to 24 Years Old (All Deaths)	45,261	127
Accidents (Total)	24,336	68
Motor-Vehicle	16,720	47
Drowning	2,330	7
Poison (solid, liquid)	1,010	3
Firearms	726	2
Other	3,550	9
Homicide	4,157	12
Suicide	3,128	9

*Deaths per 100,000 persons in specified age groups. Rates are averages for age groups, not individual ages.

Drowning data are based partially upon estimates.

Source: National Safety Council. Accident Facts 1974 Edition. Page 8.

Table 1.4 Maternal Mortality: 1963 to 1973

	All Races	White	Black And All Other Races
1964	33.3*	22.3*	89.9*
1965	31.6	21.0	83.7
1966	29.1	20.2	72.4
1967	28.0	19.5	69.5
1968	24.5	16.6	63.6
1969	22.2	15.5	55.7
1970	21.5	14.4	55.9
1971	18.8	13.0	45.3
1972	18.8	14.3	38.5
1973	15.2	10.7	34.6

*Deaths per 100,000 live births in specified groups. Deaths are classified according to the International Classification of Diseases applicable in each year.

Source: 1) National Center for Health Statistics. Vital Statistics of the United States 1969, Volume II, Mortality, Part A. Table 1.16.
2) National Center for Health Statistics. Summary Report, Final Mortality Statistics, 1970. Table 7.
3) National Center for Health Statistics. Summary Report, Final Mortality Statistics, 1971. Table 7.
4) National Center for Health Statistics. Summary Report, Final Mortality Statistics, 1972. Table 7.
5) National Center for Health Statistics. Summary Report, Final Mortality Statistics, 1973. Table 11.

Table 1.5 Infant Mortality: 1965 to 1974

	All Races	White	Black And All Other Races
1965	24.7*	21.5*	40.3*
1966	23.7	20.6	38.8
1967	22.4	19.7	35.9
1968	21.8	19.2	34.5
1969	20.9	18.4	32.9
1970	20.0	17.8	30.9
1971	19.1	17.1	28.5
1972	18.5	16.4	27.7
1973	17.7	15.8	26.2
1974	16.5	14.7	24.6

*Deaths (under one year of age) per 1,000 live births in specified groups.

1974 data are based upon a 10-percent sample. Data for other years based upon 100-percent samples.

Source: National Center for Health Statistics. Annual Summary for the United States, 1974 (Provisional Statistics), Births, Deaths, Marriages, and Divorces. Table E.

Table 1.6 Percent Children Under 18 Years Old Living with Both Parents: 1967 to 1973

	Number of Own Children*		Percent Living With Both Parents	
	Black	White	Black	White
1967	8,642**	58,722**	68	92
1968	8,752	58,765	65	92
1969	8,870	58,589	65	92
1970	8,944	58,244	64	91
1971	8,876	58,217	61	90
1972	8,584	57,252	61	89
1973	8,676	56,138	56	89

*Children under 18, never married, who are sons, daughters, stepchildren, or adopted children of a married couple, family, or sub-family head, living in families.

**In thousands, in specified groups.

Source: Bureau of the Census. The Social and Economic Status of the Black Population in the United States: 1973. Table 55.

Table 1.7 Number of Divorces and Annulments and Estimated Number of Children Involved: 1963 to 1972

	Divorces and Annulments	Children Involved in Divorces and Annulments
1963	428*	562*
1964	450	613
1965	479	630
1966	499	669
1967	523	701
1968	584	784
1969	639	840
1970	708	870
1971	773	946
1972	845	1,021

*In thousands.

Divorces and Annulments refer only to events occurring within the United States.

Number of children involved estimated from frequencies based on sample.

Source: National Center for Health Statistics. Summary Report, Final Divorce Statistics, 1972. Tables 2 and 4.

Table 1.8 Labor Force Participation of Married Women with Children, Husband Present: 1965 to 1974

	Wives With No Children Under 18 Years Old	Wives With Children Under 3 Years Old	Wives With Children Under 6 Years Old	Wives With Children 6-17 Years Old
1965	38.3*	20.0*	23.3*	42.7*
1966	38.4	21.2	24.2	43.7
1967	38.9	23.3	26.5	45.0
1968	40.1	23.4	27.6	46.9
1969	41.0	24.2	28.5	48.6
1970	42.2	25.8	30.3	49.2
1971	42.1	25.7	29.6	49.4
1972	42.7	26.9	30.1	50.2
1973	42.8	29.4	32.7	50.1
1974	43.0	31.0	34.4	51.2

*Percent in specified groups.

Data are for married women with children, husband present.

Source: Bureau of Labor Statistics. Marital and Family Characteristics of Workers, March 1974. Table 2.

Table 1.9 Labor Force Participation of Married Women with Children by Race: 1973

	All Wives	Wives With No Children Under 18 Years Old	Wives With Children Under 6 Years Old	Wives With Children 6-17 Years Old Only
White	41.2*	42.4*	30.5*	49.2*
Black And All Other Races	53.9	48.9	53.7	61.0

*Percent in specified groups.

Data are for married women with children, husband present.

Source: Bureau of Labor Statistics. Marital and Family Characteristics of the Labor Force in March 1973. Table J.

Table 1.10 Labor Force Participation of Married Women with Children by Husband's Income: 1973

	Wives With No Children Under 18 Years Old	Wives With Children Under 6 Years Old	Wives With Children 6-17 Years Old Only
Under $3,000*	32.5**	44.6**	50.9**
$3,000 to $4,999	34.9	35.7	55.4
$5,000 to $6,999	43.4	38.6	57.1
$7,000 to $9,999	52.0	37.8	56.8
$10,000 and over	46.1	26.3	46.1

*Husband's income in 1972.

**Percent in specified groups.

Data are for married women with children, husband present

Source: Bureau of Labor Statistics. Marital and Family Characteristics of the Labor Force in March 1973. Table J.

Table 1.11 Median Family Income: 1973

	Residence		Type of Family		
	Inside Metropolitan Area	Outside Metropolitan Area	Male-Headed Family	Female-Headed Family	Husband-Wife Family
White	$13,566	$10,788	$13,253	$6,560	$13,297
Black	7,779	5,780	9,549	4,226	9,729

Note: Medians above $10,000 calculated on more detailed intervals than incomes below $10,000, and therefore may not be comparable to other medians.

Source: Bureau of the Census. Money Income in 1973 of Families and Persons in the United States (Advance Report). Table 1.

Table 1.12 Percent of Children Under 18 Years Old in Poverty Families: 1974

	Black			White		
	Number: All Income Levels	Number Below Poverty Level	Percent Below Poverty Level	Number: All Income Levels	Number Below Poverty Level	Percent Below Poverty Level
Male-Headed Families	5,314*	1,151*	21.7	49,054*	3,500*	7.1
Female-Headed Families	4,062	2,668	65.7	6,294	2,680	42.6

*Number in thousands, in specified group.

Source: Bureau of the Census. Money Income and Poverty Status of Families and Persons in the United States: 1974. Table 17.

Table 1.13 Percent of Children Under 18 Years Old in Poverty Families: 1967 to 1974

	White		Black and All Other Races	
	Number Below Poverty	Percent Below Poverty	Number Below Poverty	Percent Below Poverty
1967	6,729*	11.3	4,698*	44.9
1968	6,373	10.7	4,366	41.6
1969	5,667	9.7	3,834	37.7
1970	6,138	10.5	4,097	39.6
1971	6,341	10.9	4,003	38.7
1972	5,784	10.1	4,298	41.3
1973	5,462	9.7	3,991	38.3
1974	3,500	7.1	1,151	21.7

*In thousands, in specified groups.

Beginning with 1969, data are based on 1970 census population controls; therefore, not strictly comparable to data for earlier years.

Source: 1) Bureau of the Census. Characteristics of the Low-Income Population: 1973 (Advance Report). Table 1.
2) Bureau of the Census. Money Income and Poverty Status of Families and Persons in the United States: 1974 (Advance Report). Table 17.

Table 1.14 Distribution of AFDC Funding: 1973

	Children Under 21 Years Old		Children Under 3 Years Old		Children 3-8 Years Old		Children 9-14 Years Old		Children 15-20 Years Old	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1971	7,015*	100.0	1,176*	16.8	2,494*	35.5	2,302*	32.8	1,043*	14.9
1973	7,725	100.0	1,328	17.2	2,717	35.2	2,540	32.9	1,139	14.7

*In thousands, in specified groups

Source: 1) National Center for Social Statistics. Findings of the 1971 AFDC Study Part I: Demographic and Program Characteristics. Table 33.
2) National Center for Social Statistics. Findings of the 1973 AFDC Study Part I: Demographic and Program Characteristics. Table 21.

Table 1.15 Estimated Number of Children Adopted: 1962 to 1971

	Total: All Children Adopted	Adopted Children Born Out of Wedlock	Adopted Children of Minority Races
1962	121,000	70,200	13,300
1963	127,000	76,200	12,700
1964	135,000	82,400	13,500
1965	142,000	88,000	15,600
1966	152,000	95,800	16,700
1967	158,000	99,500	17,400
1968	166,000	105,000	18,300
1969	171,000	109,000	18,800
1970	175,000	110,000	21,000
1971	169,000	101,000	22,000

Note: Data based on estimated United States totals.

National estimates of numbers of out of wedlock children adopted each year are derived from the percentage distribution according to children's birth status of all adoptions for the number of States from which information was available for that year. The number of reporting States increased from 34 in 1957 to 40 in 1971.

National estimates of numbers of children of minority races who were adopted each year are derived from the percentage distribution by race of all adoptions for the number of States from which information was available for that year. The number of reporting States increased from 33 in 1957 to 42 for 1971.

Source: National Center for Social Statistics. Adoptions in 1971. Tables 8, 10, and 11.

Table 1.16 Percent of Highschool Dropouts 14 to 24 Years Old: 1967 and 1973

	1967				1973			
	Black		White		Black		White	
	Male	Female	Male	Female	Male	Female	Male	Female
Persons 14-24 Years Old	23.9*	21.8*	11.6*	13.1*	17.6*	18.9*	10.4*	11.3*
14-15 Years Old	3.5	4.0	1.5	1.4	3.1	3.1	1.9	2.8
16-17 Years Old	11.7	14.6	7.0	9.4	10.6	10.0	8.7	9.2
18-19 Years Old	30.6	22.0	15.4	16.3	27.7	22.0	14.1	15.2
20-24 Years Old	42.6	36.1	18.8	19.0	24.9	29.0	13.7	14.2

*Percent in specified groups. Dropouts are defined as persons not enrolled in school who did not graduate from high school.

Source: National Center for Educational Statistics. Digest of Educational Statistics 1974. Table 66.

Table 2.1 AFDC Recipients and Payments: December 1965–December 1974

	Recipients	Payments
1965	4,396*	$144,355**
1966	4,666	169,155
1967	5,309	209,736
1968	6,086	272,460
1969	7,313	330,113
1970	9,659	485,877
1971	10,651	557,003
1972	11,069	598,912
1973	10,815	616,074
1974	11,006	721,142

*In thousands.

**In thousands of dollars.

Recipients: children and one or both parents or one adult caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.

Source: 1) National Center for Social Statistics. Trend Report: Graphic Presentation of Public Assistance and Related Data Demographic and Program Characteristics and Financial Characteristics of Recipients 1971. Pages 3 and 5.
2) personal communication.

Table 2.2 Licensed or Approved Day Care Facilities: 1972

	Total		Public		Voluntary		Independent	
	Number	Capacity	Number	Capacity	Number	Capacity	Number	Capacity
Day Care Centers	17,046	655,858	1,575	56,336	5,982	255,670	8,309	298,523
Family Day Care Homes	47,496	164,790	9,717	34,075	6,569	15,986	31,023	113,431

Table based upon unpublished data.

Data are incomplete and exclude Arizona, California, District of Columbia, Indiana, and Virginia. 1971 data were used for Delaware, Iowa, Michigan, New York, Pennsylvania, and the Virgin Islands.

Day care auspices were not reported for New Jersey and Tennessee, and family day care home auspices were not reported for Tennessee.

Source: National Center for Social Statistics. Children Served by Public Welfare Agencies and Voluntary Child Welfare Agencies and Institutions, March 1972 (unpublished data). Table 13.

Table 2.3 Preprimary School Enrollment: October, 1973

	Children Enrolled in Nursery Schools		Children Enrolled in Kindergarten	
	Percent Enrolled In Public Schools	Percent Enrolled In Private Schools	Percent Enrolled In Public Schools	Percent Enrolled In Private Schools
1968	32.1	67.9	82.6	17.5
1969	28.2	71.8	81.6	18.4
1970	30.3	69.6	83.0	17.0
1971	29.7	70.3	82.0	18.0
1972	31.0	69.0	83.8	16.2
1973	29.9	70 1	83.5	16.5

Source: Bureau of the Census. Nursery School and Kindergarten Enrollment: October 1973. Table E.

Table 2.4 Preprimary School Aged Children Enrolled in Nursery School and Kindergarten: October, 1964 to October, 1973

	3 year olds	4 year olds	5 year olds
1964	4.3*	14.9*	58.1*
1965	4.9	16.1	60.6
1966	6.0	18.9	62.2
1967	6.8	21.3	65.4
1968	8.3	22.8	66.0
1969	8.7	23.1	68.9
1970	12.9	27.3	69.3
1971	12.4	29.8	73.7
1972	15.5	33.6	76.1
1973	14.5	34.2	76.0

*Percent enrolled in specified groups. Data exclude 5 year old children enrolled above kindergarten.

Source: Bureau of the Census. Nursery School and Kindergarten Enrollment: October 1973. Table B.

Table 2.5 Modal Grade Enrollment: October, 1972

	Percent Enrolled							
	2 or More Years Below Modal Grade*				1 Year Below Modal Grade			
	White		Black		White		Black	
	Male	Female	Male	Female	Male	Female	Male	Female
6 Years Old	.4	0.0	0.0	0.0	6.8	4.5	3.2	2.0
7 Years Old	0.0	0.0	0.0	0.0	12.6	8.8	17.8	14.1
8 Years Old	.7	.5	.7	2.1	15.9	11.1	21.4	16.4
9 Years Old	2.0	.9	2.2	1.2	18.8	12.2	30.1	23.0
10 Years Old	2.6	1.2	3.1	3.8	19.0	14.1	27.9	19.0
11 Years Old	3.9	1.7	10.1	3.6	20.1	12.8	27.2	23.2
12 Years Old	4.0	2.1	11.0	6.3	21.3	12.5	32.6	16.8
13 Years Old	1.8	2.4	9.0	5.5	22.6	14.4	26.6	21.3
Unweighted Average	1.9	1.1	4.5	2.8	17.1	11.3	23.3	17.0

(Continued on Following Page)

Table 2.5 Modal Grade Enrollment: October, 1972
(Continued)

	Percent Enrolled							
	In Modal Grade				1 or More Years Above Modal Grade			
	White		Black		White		Black	
	Male	Female	Male	Female	Male	Female	Male	Female
6 Years Old	84.6	83.1	83.8	78.9	8.2	12.4	13.0	18.7
7 Years Old	80.1	79.7	69.5	77.0	7.2	11.6	12.4	8.9
8 Years Old	74.7	77.9	72.3	67.1	8.6	10.4	5.9	14.3
9 Years Old	72.3	76.7	58.7	63.0	6.9	10.2	9.4	12.5
10 Years Old	70.6	75.2	56.1	66.1	7.9	9.4	13.2	10.7
11 Years Old	67.6	76.5	53.3	62.4	8.4	9.0	9.7	10.8
12 Years Old	63.8	74.5	48.2	64.0	10.9	10.9	8.2	12.5
13 Years Old	67.7	73.3	57.9	59.2	7.9	9.8	6.6	14.0
Unweighted Average	72.7	77.1	62.5	67.2	8.3	10.5	9.8	12.8

*Modal grade is defined as: 6 years old, grade 1; 7 years old, grade 2; 8 years old, grade 3; 9 years old, grade 4; 10 years old, grade 5; 11 years old, grade 6; 12 years old, grade 7; 13 years old, grade 8.

Figure 2.5 indicates unweighted average percentages 6 through 13.

Source: Bureau of the Census. Social and Economic Characteristics of Students October 1972. Table 15.

Table 2.6 Percent of Handicapped Pupils Receiving Special Instruction or Assistance in School: Spring, 1970

	All Schools		Elementary		Secondary	
	Number Handicapped Pupils	Percent Receiving Special Instruction	Number Handicapped Pupils	Percent Receiving Special Instruction	Number Handicapped Pupils	Percent Receiving Special Instruction
Speech Impairments	1,793*	68**	1,520*	71**	198*	53**
Learning Disabilities	1,160	56	779	60	314	55
Mentally Retarded	936	78	606	75	257	85
Emotionally Disturbed	556	45	371	47	160	44
Hard of Hearing	131	32	71	29	50	41
Deaf	23	90	18	98	3	55
Crippled	82	37	40	42	36	31
Partially Sighted	64	27	30	37	24	21
Blind	6	94	3	99	3	93

*Numbers in thousands, by specific type of handicap.

**Percent receiving special instruction enumerates pupils who received instruction in separate (special) classes in regular classes by regular teachers, through individualized special instruction, or through assistance by specialized personnel.

Pupils in combined schools, with both elementary and secondary grades, are included in the totals but not in the detail by school level.

Source: National Center for Educational Statistics. Statistics on Education for the Handicapped in Local Public Schools. Table 2:1 for each handicap.

Table 2.7 Percent Population Aged 1-5 Years Below Nutritional Standard: 1971 to 1972

	All Income Levels			Income Below Poverty Level			Income Above Poverty Level		
	All Races	White	Black	All Races	White	Black	All Races	White	Black
Calcium	14.95*	12.24*	29.96*	22.54*	14.42*	35.26*	13.36*	12.14*	24.96*
Iron	94.82	94.81	94.63	94.16	94.46	93.61	94.95	94.88	95.29
Vitamin A	39.84	38.54	47.89	49.25	51.51	46.07	38.08	36.91	51.01
Vitamin C	45.81	45.13	50.45	54.42	58.23	48.54	43.58	42.82	52.91

*Percent failing to meet specified nutritional standards.

Note: Data based upon preliminary survey findings, involving 24-hour recall of dietary intake.

Dietary Intake Standards: Calcium, 450 mg; Iron, 15 mg; Vitamin A, 2000 IU; Vitamin C, 40 mg.

Source: National Center for Health Statistics. Preliminary Findings of the First Health and Nutrition Examination Survey, United States, 1971-1972. Tables 21, 24, 27, 30.

Table 2.8 Number of Children Participating in the National School Lunch Program: 1968 to 1974

	Total Number Participating	Number Receiving Free or Reduced Price Lunches
1968	20.6*	2.7*
1969	22.1	3.3
1970	23.1	5.2
1971	24.6	7.3
1972	24.9	8.3
1973	25.2	9.0
1974	24.9	9.4

*In millions.

Data are for the peak month of fiscal year, and are based upon a preliminary report.

Source: Food and Nutrition Service/Program Reporting Staff. Annual Statistical Review Preliminary Report: Food and Nutrition Programs Fiscal Year 1974. Page 5.

Table 2.9 Patient Care Episodes Under 18 Years of Age by Type of Psychiatric Facility: 1971

	Number of Episodes*	Percent of All Episodes
All Psychiatric Services	771,874	100.0
Inpatient Psychiatric Services	139,658	18.1
State and County Mental Hospitals	39,196	5.1
Private Mental Hospitals	7,668	1.0
General Hospital Inpatient Psychiatric Units	46,065	6.0
Residential Treatment Centers for Emotionally Disturbed Children	28,637	3.7
Community Mental Health Centers	18,092	2.3
Outpatient Psychiatric Services	632,216	81.9
Community Mental Health Centers	194,877	25.2
All Other Outpatient Psychiatric Services	437,339	56.7

*Patient care episodes are defined as the number of residents in inpatient psychiatric services or on the rolls of outpatient psychiatric services at the beginning of the year plus the total additions to these services during the year.

Total all psychiatric services and inpatient psychiatric services excludes inpatient psychiatric services of Veterans Administration hospitals.

Community Mental Health Center data are for the under 20 year age group.

Source: National Institute of Mental Health. Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, United States 1971. Table 1.

Table 2.10 Admissions to Outpatient Psychiatric Services: 1970 to 1971

	All Races			White			Black And All Other Races		
	Both Sexes	Male	Female	Both Sexes	Male	Female	Both Sexes	Male	Female
Under 18 Years Old	358.2*	450.4*	262.7*	339.9*	455.2*	260.6*	349.3*	423.7*	274.4*
Under 14 Years Old	288.3	404.1	168.1	293.2	420.1	160.6	262.8	317.8	207.3
14-17 Years Old	603.8	614.0	593.4	589.1	576.4	602.2	694.6	849.4	540.6
All Ages	484.5	478.6	490.2	464.1	460.6	467.5	628.8	607.4	648.6

*Admissions per 100,000 in specified groups.

Source: National Institute of Mental Health. Admissions to Outpatient Psychiatric Services by Age, Sex, Color, and Marital Status, June 1970-May 1971. Table 1.

Table 2.11 Percent Arrests of Persons Under 15 Years of Age: 1973

	Arrests of Persons Under 15 Years Old		Arrests of Persons Under 18 Years Old		Arrests of Persons 18 Years Old and Over	
	Number	Percent	Number	Percent	Number	Percent
All Arrests	614,716	100.0	1,717,364	100.0	4,782,498	100.0
Larceny-Theft	146,910	23.9	310,452	18.1	333,738	7.0
Violations of Curfew, Loitering Ordinance, and Runaways	104,982	17.1	296,436	17.3	--	--
Burglary-Breaking or Entering	73,139	11.9	170,228	9.9	146,044	3.0
Vandalism	51,377	8.4	83,428	4.9	37,583	0.8
Drunkenness and Disorderly Conduct	40,321	6.3	138,278	8.1	1,512,764	31.6
Other Assaults	21,013	3.4	53,044	3.1	222,061	4.6
Auto Theft	17,736	2.8	66,868	3.9	51,512	1.1
Narcotic Drug Laws	16,222	2.6	127,316	7.4	356,926	7.5
Robbery	11,015	1.8	34,374	2.0	67,520	1.4
Aggravated Assault	8,200	1.3	26,270	1.5	128,621	2.7
Liquor Laws	7,178	1.2	74,690	4.3	109,123	2.3

Source: Federal Bureau of Investigation. Crime in the United States 1973. Table 30.

Table 2.12 Criminal Victimization: 1973

	Victims of Crimes Against Persons						
	12-15 Years Old	16-19 Years Old	20-24 Years Old	25-34 Years Old	35-49 Years Old	50-64 Years Old	Over 64 Years Old
Male Victims	267.0*	285.7*	246.7*	161.0*	104.3*	67.8*	40.3*
Female Victims	203.9	189.4	159.1	113.8	86.8	54.4	25.6

*Rates per 1,000 persons in specified groups. Data pertain to crimes committed in one calendar year.

Note: Data based on survey of persons 12 years old and over.

Source: National Criminal Justice Information and Statistics Service. Criminal Victimization in the United States: A National Crime Panel Survey Report, 1973 Advance Report, Vol. I. Table 4.

Table 2.13 Motivation for Abuse of All Drugs Nationwide: July, 1973 to February, 1974

	Psychic Effects	Dependence	Self-Destruction	Other
15 years old and under	60*	7*	22*	10*
16-19 years old	57	17	20	6
20-29 years old	36	28	30	7
30-39 years old	23	24	46	8
40-49 years old	16	21	53	10
50 years old and over	13	14	61	12

*Percent in specified groups.

Source: Drug Enforcement Administration. Drug Abuse Warning Network Phase II Report July 1973-March 1974. Table IV3.

Table 2.14 Reported Cases of Venereal Disease: 1963-1974

	Syphilis		Gonorrhea	
	Number of Cases	Rate	Number of Cases	Rate
1963	128,450	69.3*	270,076	145.7*
1964	118,247	62.9	290,603	154.5
1965	113,018	59.7	310,155	163.8
1966	110,128	57.1	334,949	173.6
1967	103,546	53.2	375,606	193.0
1968	98,195	49.9	431,380	219.2
1969	96,679	48.1	494,227	245.9
1970	87,934	43.8	573,200	285.2
1971	94,383	46.5	624,371	307.5
1972	95,076	46.3	718,401	349.7
1973	90,609	43.9	809,681	392.2
1974	84,164	40.4	874,166	420.1

*Rate per 100,000 population. Syphilis cases include all stages, and stage not reported.

Source: Center for Disease Control. VD Fact Sheet 1974. Table 3.

Table 2.15 Congenital Syphilis: 1957, 1965, 1974

	Number of Cases	Rate
1957	180	.4*
1965	373	.8
1970	300	.8
1971	400	1.1
1972	422	1.3
1973	356	1.1
1974	307	1.0

*Rate per 10,000 live births.

Source: Center for Disease Control. VD Fact Sheet 1974. Table 4b.

Table 2.16 Reported Cases of Selected Communicable Diseases

	Poliomyelitis	Pertussis	Measles	Diphtheria	Tuberculosis	Hepatitis
1964	122*	13,005*	458,083*	293*	50,874*	37,740*
1965	72	6,799	261,904	164	49,016	33,856
1966	113	7,717	204,136	209	47,767	34,356
1967	41	9,718	62,705	219	45,647	41,367
1968	53	4,810	22,231	260	42,623	50,722
1969	20	3,285	25,826	241	39,120	54,325
1970	33	4,249	47,351	435	37,137	65,107
1971	21	3,036	75,290	215	35,217	69,162
1972	31	3,287	32,275	152	32,882	63,476
1973	8	1,759	26,690	228	31,015	59,200

*Number of cases. Poliomyelitis enumerates all cases, including paralytic. Hepatitis enumerates both Hepatitis A and B. Tuberculosis enumerates newly reported active cases; data for 1973 are based upon provisional statistics.

Source: Center for Disease Control. Reported Morbidity and Mortality in the United States 1973. Table 2(A).

Table 2.17 Major Immunizations for Children 1-4 Years Old: 1966 to 1974

	Percent Immunized			
	Rubella	Measles	Poliomyelitis	DTP
1966		45.4	70.2**	74.5***
1967		56.4	70.9	77.9
1968		58.8	68.3	76.5
1969		61.4	67.7	77.4
1970	37.2*	57.2	65.9	76.1
1971	51.2	61.0	67.3	78.7
1972	56.9	62.2	62.9	75.6
1973	55.6	61.2	60.4	72.6
1974	59.8	64.5	63.1	73.9

*The rubella vaccine was licensed in June, 1969.

**Percentage reflects children who have received three or more doses of vaccine.

***Percentage reflects children who have received three or more doses of diphtheria-tetanus-pertussis (DTP) vaccine.

Source: Center for Disease Control. United States Immunization Survey: 1974. Tables 1a, 1b, 1c, and 1d.

Appendix 2

Federal Programs

DEPARTMENT OF AGRICULTURE

Farmers Home Administration

10.410	Low to Moderate-Income Housing Loans
10.411	Rural Housing Site Loans
10.415	Rural Rental Housing Loans
10.417	Very Low-Income Housing Repair Loans
10.420	Rural Self-Help Housing Technical Assistance

Extension Service

10.500	Cooperative Extension Service

Food and Nutrition Service

10.550	Food Distribution
10.551	Food Stamps
10.552	Special Food Service Program for Children
10.553	School Breakfast Program
10.554	Nonfood Assistance for School Food Service Programs
10.555	National School Lunch Program
10.556	Special Milk Program for Children
10.557	Special Supplemental Food Program for Women, Infants, and Children

Forest Service

10.661	Youth Conservation Corps--Grants to States

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

13.210	Comprehensive Public Health Services-Formula Grants (A)
13.211	Crippled Children's Services
13.217	Family Planning Projects
13.224	Health Services Development--Project Grants
13.228	Indian Health Services
13.229	Indian Sanitation Facilities
13.231	Maternal and Child Health Research
13.232	Maternal and Child Health Services
13.233	Maternal and Child Health Training
13.235	Drug Abuse Community Service Programs
13.237	Mental Health-Hospital Improvement Grants
13.238	Mental Health-Hospital Staff Development Grants
13.239	Narcotic Addict Rehabilitation Act Contracts
13.240	Mental Health-Community Mental Health Centers
13.241	Mental Health Fellowships
13.242	Mental Health Research Grants
13.243	Alcohol, Drug Abuse, and Mental Health Administration Scientific Communications and Public Education
13.244	Mental Health Training Grant
13.246	Migrant Health Grants
13.251	Alcohol Community Service Programs
13.252	Alcohol Demonstration Programs
13.254	Drug Abuse Demonstration Programs
13.256	Office for Health Maintenance Organizations
13.257	Alcohol Formula Grants
13.258	National Health Service Corps
13.259	Mental Health-Children's Services
13.260	Family Planning Services-Training Grants
13.261	Family Health Centers
13.266	Childhood Lead-Based Paint Poisoning Control
13.267	Urban Rat Control
13.268	Disease Control-Project Grants
13.269	Drug Abuse Prevention Formula Grants
13.270	Alcohol Fellowships
13.271	Alcohol Research Development Awards
13.272	Alcohol National Research Service Awards
13.273	Alcohol Training Programs
13.275	Drug Abuse Education Programs
13.277	Drug Abuse Research Development Awards
13.278	Drug Abuse National Research Service Awards
13.279	Drug Abuse Research Programs
13.280	Drug Abuse Training Programs
13.281	Mental Health Research Development Awards

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (Continued)

13.282	Mental Health National Research Service Awards
13.283	Center for Disease Control--Investigations, Surveillance, and Technical Assistance
13.284	Emergency Medical Services
13.289	President's Council on Physical Fitness and Sports
*	Sudden Infant Death Syndrome
*	Sickle Cell Disease Program
*	Community Health Centers
*	Federal Health Programs Service

Office of Education

13.403	Bilingual Education
13.410	Dropout Prevention
13.421	Educational Personnel Training Grants-Career Opportunities
13.427	Educationally Deprived Children -Handicapped
13.428	Educationally Deprived Children -Local Educational Agencies
13.429	Educationally Deprived Children -Migrants
13.430	Educationally Deprived Children State Administration
13.431	Educationally Deprived Children in State Administered Institututions Serving Neglected or Delinquent Children
13.433	Follow Through
13.443	Handicapped-Research and Demonstration
13.444	Handicapped Early Childhood Assistance
13445	Handicapped Innovative Programs -Deaf-Blind Centers
13.446	Handicapped Media Services and Captioned Films
13.447	Handicapped Physical Education and Recreation Research
13.448	Handicapped Physical Education and Recreation Training
13449	Handicapped Preschool and School Programs
13.450	Handicapped Regional Resource Centers
13.451	Handicapped Teacher Education
13.452	Handicapped Teacher Recruitment and Information
13.465	Library Services-Interlibrary Cooperation
13.477	School Assistance in Federally Affected Areas-Construction
13.478	School Assistance in Federally Affected Areas-Maintenance and Operation
13.480	School Library Resources, Textbooks, and Other Instructional Materials
13.485	Strengthening State Departments of Education-Grants for Special Projects
13.486	Strengthening State Departments of Education-Grants to States
13.488	Talent Search
13.489	Teacher Corps-Operations and Training
13.493	Vocational Education--Basic Grants to States
13.494	Vocational Education--Consumer and Homemaking
13.495	Vocational Education--Cooperative Education
13.496	Vocational Education--Curriculum
13.498	Vocational Education--Research
13.499	Vocational Education--Special Needs
13.501	Vocational Education-Work Study
13.502	Vocational Education--Innovation
13.511	Educationally Deprived Children --Special Grants for Urban and Rural Schools
13.512	Educationally Deprived Children --Special Incentive Grants
13.516	Supplementary Educational Centers and Services--Special Programs and Projects
13.519	Supplementary Educational Centers and Services, Guidance, Counseling, and Testing
13.520	Special Programs for Children with Specific Learning Disabilities
13.523	School Health and Nutrition Services for Children From Low-Income Families
13.525	Emergency School Aid Act--Basic Grants to Local Educational Agencies

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*An OMB catalog number is unavailable.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (Continued)

13.526	Emergency School Aid Act--Pilot Programs (Special Programs and Projects)
13.528	Emergency School Aid Act--Bilingual Education Projects
13.529	Emergency School Aid Act--Special Programs and Projects
13.530	Emergency School Aid Act--Educational Television
13.532	Emergency School Aid Act--Special Programs
13.533	Right to Read--Elimination of Illiteracy
13.534	Indian Education--Grants to Local Educational Agencies
13.535	Indian Education--Special Programs and Projects
13.549	Ethnic Heritage Studies Program
13.551	Indian Education--Grants to Non-Federal Educational Agencies
13.560	Regional Education Programs for Deaf and Other Handicapped Persons
*	Drug Education
*	Environmental Education
*	Handicapped State Grant Program

Office of Human Development

13.612	Native American Programs

Office of Child Development

13.600	Child Development--Head Start
13.601	Child Development--Technical Assistance
13.608	Child Development--Child Welfare Research and Demonstration Grants
13.628	Child Development--Child Abuse and Neglect Prevention and Treatment
*	Exploring Childhood

Office of Youth Development

*	Runaway Youth Program

Rehabilitation Services Administration

13.630	Developmental Disabilities--Basic Support
13.631	Developmental Disabilities--Special Projects
13.632	Developmental Disabilities--Demonstration Facilities and Training

Office for Handicapped Individuals

*	Vocational Rehabilitation Act of 1973, Public Law 93-112, Title IV, Section 405

Social and Rehabilitation Service

13.707	Child Welfare Services
13.714	Medical Assistance Program
13.748	Work Incentives Program--Child Care--Employment Related Supportive Services
13.754	Public Assistance--Social Services
13.761	Public Assistance--Maintenance Assistance
13.766	Public Assistance Research
13.768	Community Services Training Grants

Social Security Administration

13.802	Social Security--Disability Insurance
13.803	Social Security--Retirement Insurance
13.805	Social Security--Survivors Insurance
13.806	Special Benefits for Disabled Coal Miners
13.807	Supplemental Security Income

Public Health Service

13.864	Population Research
13.865	Child Health Research

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Housing Production and Mortgage Credit/FHA

14.103	Interest Reduction Payments--Rental and Cooperative Housing for Lower Income Families
14.104	Interest Subsidy--Acquisition and Rehabilitation of Homes for Resale to Lower Income Families
14.105	Interest Subsidy--Homes for Lower Income Families
14.106	Interest Subsidy--Purchase of Rehabilitated Homes by Lower Income Families
14.108	Major Home Improvement Loan Insurance-Housing Outside Urban Renewal Area
14.147	Public Housing--Home Ownership for Low Income Families

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (Continued)

14.148	Public Housing--Leased
14.149	Rent Supplements--Rental Housing for Lower Income Families
14.156	Lower-Income Housing Assistance Program

Federal Disaster Assistance Administration

14.701	Disaster Assistance

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

15.101	Indian Agricultural Extension
15.103	Indian Social Services--Child Welfare Assistance
15.105	Indian Education--Contracts with Indian School Boards
15.110	Indian Education--Federal Schools
15.113	Indian Social Services--General Assistance
15.115	Indian Housing--Development
15.116	Indian Housing--Improvement
15.130	Indian Education--Assistance to Non-Federal Schools
15.132	Indian Social Services--Counseling

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

16.005	Public Education on Drug Abuse--Technical Assistance

Civil Rights Division

16.100	Desegregation of Public Education

Law Enforcement Assistance Administration

*	Deinstitutionalization of Status Offenders
*	Diversion

DEPARTMENT OF LABOR

Manpower Administration

17.226	Work Incentives Program
17.303	Minimum Wage and Hour Standards
17.305	Women's Special Employment Assistance

APPALACHIAN REGIONAL COMMISSION

23.004	Appalachian Health Demonstrations
23.013	Appalachian Child Development

LIBRARY OF CONGRESS

42.001	Books for the Blind and Physically Handicapped

COMMUNITY SERVICES ADMINISTRATION

49.002	Community Action

VETERANS ADMINISTRATION

Department of Veterans Benefits

64.102	Compensation for Service-Connected Deaths for Veterans' Dependents
64.105	Pension to Veterans' Widows and Children
64.110	Veterans Dependency and Indemnity Compensation for Service-Connected Death

ACTION

72.001	The Foster Grandparents Program
72.003	Volunteers in Service to America
72.009	The Youth Challenge Program

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